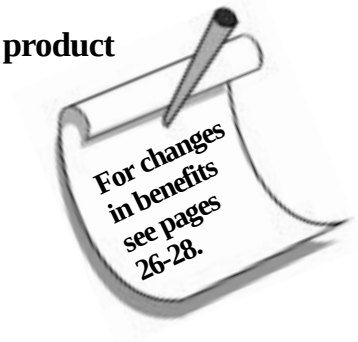
FreeState Health Plan, Inc. 1999

A Health Maintenance Organization with a Point of Service product



Enrollment in this Plan is limited; see pages 10–11 for requirements.

Enrollment code:
LD1 Self Only
LD2 Self and Family

Service area: Services from Plan providers are available only in the area described on pages 9–10.

Special Notice: CareFirst HMO has merged into FreeState Health Plan. Federal employees and annuitants enrolled in CareFirst HMO, enrollment code JQ, will be automatically transferred into FreeState Health Plan, enrollment code LD, effective in January 1999, unless they select another health benefits carrier during the 1998 Open Season.

Special Notice: Columbia Medical Plan, Inc. has merged into FreeState Health Plan. Federal employees and annuitants enrolled in Columbia Medical Plan, enrollment code 67, will be automatically transferred into FreeState Health Plan, enrollment code LD, effective in January 1999, unless they select another health benefits carrier during the 1998 Open Season.

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

Authorized for distribution by the:

United States Office of Personnel Management

Federal Employees Health Benefits Program

RI 73-146

FreeState Health Plan

FreeState Health Plan, Inc., 100 S. Charles Street, Baltimore, MD 21201 has entered into a contract (CS 2010) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called FreeState Health Plan, or FSHP or the Plan.

This brochure is the official statement of benefits on which you can rely. A person enrolled in the Plan is entitled to the benefits stated in this brochure. If enrolled for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1999, and are shown on page 26 of this brochure.

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Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD. This could result in CRIMINAL PENALTIES. Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital or pharmacy, charged your plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider 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 plan at 410/654-8675 or 800/445-6036 and explain the situation.
- If the matter is not resolved after speaking to your plan (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 services 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.

General Information

Confidentialty

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

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 Plan. 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 or Plan facility 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 Plan.

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 and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. **As a member of this Plan, once your enrollment is effective, you will be covered only for services provided or arranged by a Plan doctor except in the case of emergency as described on page 15 or when you self-refer for point of service (POS) benefits as described on pages 21 and 22.** If you are confined in a hospital on the effective date, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See “If you are hospitalized” on page 4.

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

If you are hospitalized

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

Your responsibility

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

Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in this Plan; if you changed plans or plan options, see "If you are a new member" above. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period; both parent and child are covered only for care received from Plan providers, except for emergency or POS benefits.
- 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 Plan does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions, including divorces, of covered family members to the Plan promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

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

You may also remain enrolled in this Plan when you join a Medicare prepaid plan.

Contact your local Social Security Administration (SSA) office for information on local Medicare prepaid 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. See page 23 for information on the Medicare prepaid plan offered by this 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 generally will be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

Former spouse coverage

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

Temporary continuation of coverage (TCC)

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

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

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

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

Notification and election requirements

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

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

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

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

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

Conversion to individual coverage

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

Certificate of Creditable Coverage

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

Facts about this Plan

This Plan is a comprehensive medical plan, sometimes called a health maintenance organization (HMO) that offers a point of service, or POS, product. Whenever you need services, you may choose to obtain them from your personal doctor within the Plan's provider network or go outside the network for treatment. Within the Plan's network you are required to select a personal doctor who will provide or arrange for your care and you will pay minimal amounts for comprehensive benefits. There are no claim forms when Plan doctors are used. When you choose a non-Plan doctor or other non-Plan provider under the POS option, you will pay a substantial portion of the charges and the benefits available may be less comprehensive. See pages 21–22 for more information.

Your decision to join an HMO should be based on your preference for the plan's benefits and delivery system, not because a particular provider is in the plan's network. You cannot change plans because a provider leaves the HMO.

Because the Plan provides or arranges your care and pays the cost, it seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, it can afford to offer a comprehensive range of benefits. In addition to providing comprehensive health services and benefits for accidents, illness and injury, the Plan emphasizes preventive benefits such as office visits, physicals, immunizations and well-baby care. You are encouraged to get medical attention at the first sign of illness.

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 FreeState Health Plan at 410/654-8675 or you may write: FreeState Health Plan, 10455 Mill Run Circle, 01-780 Owings Mills, MD 21117.

Information that must be made available to you includes:

- Disenrollment rates for 1997.
- Compliance with State and Federal licensing or certification requirements and the dates met. If noncompliant, the reason for noncompliance.
- Accreditation's 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.

Who provides care to Plan members?

FreeState Health Plan, Inc. is a Health Maintenance Organization (HMO). An affiliate corporation of Blue Cross and Blue Shield of Maryland, FreeState is a mixed model HMO, contracting with medical centers and physicians to provide health care services to you.

Medical care is available to you 24 hours a day, seven days a week within the service area, and on an emergency basis if you are away.

Upon joining FreeState Health Plan, you select a participating medical center or physician to provide health care to you and your family. Each family member may select a different medical center or physician to provide health services. You then will choose a primary care doctor at the center for yourself and each member of your family.

Role of a primary care doctor

The first and most important decision each member must make is the selection of a primary care doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialists, are obtained. It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other providers are covered only **when** you have been referred by your primary care doctor or when you use POS benefits, with the following exceptions: a woman may see her Plan gynecologist for her annual routine examination without a referral and treatment for mental health conditions and substance abuse may be obtained by calling Green Spring Health Management Services; at 800/245-7013. Green Spring Health Management Services, or other mental health administrator, as determined by the Plan, will determine all appropriate referrals to specialists and facilities for treatment of mental conditions and substance abuse. Primary care doctors in this Plan may be limited as to which participating specialists he or she may utilize for referrals.

This Plan has an option that allows a member to receive services outside of the standard HMO network. Read this brochure carefully to get a clear understanding of the benefits available through FreeState's New Choice (a self referral program). For more information regarding this option, see pages 21–22.

Facts about this Plan *continued*

Choosing your doctor

The Plan's provider directory lists medical centers and doctors with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Plan's Client Services Department at 410/654-8675, 800/445-6036, 410/998-5768 TDD, 800/828-3196 TDD; you can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. Important note: **When you enroll in this plan, services (except for emergency or POS benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider, cannot be guaranteed.**

If you enroll, you will be asked to complete a form and send it directly to the Plan, indicating the name of the medical center you are selecting for you and each member of your family. Subscribers may elect to change centers for the following reasons: during the annual open season for Federal enrollees, or change of residence. Requests for transfer are considered on an individual basis for subscribers citing reasons other than those stated above. Generally, 30 days are required for a transfer of medical centers to occur.

If you are receiving services from a doctor that leaves the Plan, the Plan will pay for covered services until the Plan can arrange with you for you to be seen by another participating doctor.

Referrals for specialty care

Except in a medical emergency, or when a primary care doctor has designated another doctor to see patients or when you choose to use the POS benefits, to receive standard HMO benefits you must contact your primary care doctor for a referral before seeing any other doctor or obtaining special services. Referral to a participating specialist is given at the primary care doctor's discretion; if specialists or consultants are required beyond those participating in the Plan, the primary care doctor will make arrangements for appropriate referrals.

When you receive a referral from your primary care doctor, you must return to the primary care doctor after the consultation unless your doctor authorizes additional visits. For standard HMO benefits, all follow-up care must be provided or arranged by the primary care doctor. On referrals, the primary care doctor will give specific instructions to the consultant as to when services are authorized. If additional services or visits are suggested by the consultant, you must first check with your primary care doctor. Do not go to the specialist unless your primary care doctor has arranged for and the Plan has issued an authorization for the referral in advance.

If you have a chronic, or serious medical condition that causes you to see a Plan specialist frequently, your primary care doctor will develop a treatment plan with you and your health plan that allows an adequate number of direct access visits with that specialist. The treatment plan will permit you to visit your specialist without the need to obtain further referrals.

Authorizations

The Plan will provide benefits for covered services only when the services are medically necessary to prevent, diagnose or treat your illness or condition. Your primary care doctor must obtain the Plan's determination of medical necessity before you may be hospitalized, referred for specialty care or obtain follow-up care from a specialist.

For new members

If you are already under the care of a specialist who is a Plan participant, you must still obtain a referral from a Plan primary care doctor for the care to be covered by the Plan. If the doctor who originally referred you to this specialist is now your Plan primary doctor, you need only call to explain that you are now a Plan member and ask that you be referred for your next appointment.

If you are selecting a new primary care doctor and want to continue with this specialist, you must schedule an appointment so the primary care doctor can decide whether to treat the condition directly or refer you back to the specialist.

Hospital care

If you require hospitalization, your primary care doctor or authorized specialist will make the necessary arrangements and continue to supervise your care.

Out-of-pocket maximum

In addition to your share of the premiums, your out-of-pocket expenses for benefits covered under this Plan and authorized by Plan providers are limited to the stated copayments which are required for a few benefits.

Out-of-pocket maximum *continued*

The POS, Self-Referral Program, has an out-of-pocket maximum based on deductible and coinsurance payments. Once out-of-pocket expenses for deductibles and coinsurance reach $2,000 per member or $4,000 per family, the Plan will pay 100% of the allowed benefit for the remainder of the calendar year. Coinsurance amounts for failure to obtain preauthorization do not contribute toward the out-of-pocket maximum.

You should maintain accurate records of the copayments made, as it is your responsibility to determine when the copayment maximum is reached. You are assured a predictable maximum in out-of-pocket costs for covered health and medical needs. Copayments are due when service is rendered, except for emergency care.

Deductible 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 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 January 1.

Submit claims promptly

When you are required to submit a claim to this Plan for covered expenses, submit your claim promptly. The Plan will not pay benefits for claims submitted later than December 31 of the calendar year following the year in which the expense was incurred, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Experimental/ investigational determinations

Any treatment, service, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which the Plan determines to be experimental or investigative utilizing the following considerations:

- If the service is not recognized in accordance with generally accepted medical standards as being safe and effective for use in the treatment of the condition in question, whether or not the service is authorized by law for use in testing or other studies on human patients; or,
- If the service requires approval by any governmental authority prior to use where such approval has not been granted when the service is to be rendered; or,
- If in the case of a drug or therapeutic regiment or device, the service is not approved for human use by the Federal Food and Drug Administration.

Other considerations

Plan providers will follow generally accepted medical practice in prescribing any course of treatment. Before you enroll in this Plan, you should determine whether you will be able to accept treatment or procedures that may be recommended by Plan providers.

The Plan's service area

The service area for this Plan, where Plan providers and facilities are located, is described below. You must live or work in the service area to enroll in this Plan.

Serving: Maryland, Most of Southern Pennsylvania, Northeastern West Virginia and Washington DC

The service area for this Plan includes the following areas:

Baltimore City

Maryland Counties

Allegany	Cecil	Howard	Somerset
Anne Arundel	Charles	Kent	Talbot
Baltimore	Dorchester	Montgomery	Washington
Calvert	Frederick	Prince George's	Wicomico
Caroline	Garrett	Queen Anne's	Worcester
Carroll	Harford	St. Mary's	

Pennsylvania—Zip Codes Listed

15545	17250	17272	17321	17340	17361
17225	17256	17302	17325	17343	17363
17235	17268	17314	17329	17349	
17236	17270	17320	17331	17352	

Facts about this Plan *continued*

The Plan's service area *continued*

West Virginia—Zip Codes Listed

25401	25427
25419	25443

Benefits for care outside the service area are limited to emergency services, as described on page 15, and to services covered under the Point of Service Benefits, as described on pages 21–22.

If you or a covered family member move outside the service area, you may enroll in another approved plan. It is not necessary to wait until you move or for the open season to make such a change; contact your employing office or retirement system for information if you are anticipating a move.

General Limitations

Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment of your Plan doctor, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. 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 this Plan or be used in the prosecution or defense of a claim under this Plan. This brochure is the official statement of benefits on which you rely.

Circumstances beyond Plan control

In the event of major disaster, epidemic, war, riot, civil insurrection, disability of a significant number of Plan providers, complete or partial destruction of facilities, or other circumstances beyond the Plan's control, the Plan will make a good faith effort to provide or arrange for covered services. However, the Plan will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

Arbitration of claims

Any claim for damages for personal injury, mental disturbance or wrongful death arising out of the rendition or failure to render services under this contract must be submitted to binding arbitration.

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 Plan and complete all necessary documents and authorizations requested by the Plan.

Medicare

If you or a covered family member is enrolled in this Plan and Medicare Part A and /or Part B, the Plan will coordinate benefits according to Medicare's determination of which coverage is primary. However, this Plan will not cover services, except those for emergencies, unless you use Plan providers or the services are covered under this Plan's POS benefits. You must tell your Plan that you or your family member is eligible for Medicare. Generally, that is all you will need to do, unless your Plan tells you that you need to file a Medicare claim.

Group health insurance and automobile insurance

This coordination of benefits (double coverage) provision 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 Plan.

When there is double coverage for covered benefits, other than emergency services from non-Plan providers, this Plan will continue to provide its benefits in full, but is entitled to receive payment for the services and supplies provided, to the extent that they are covered by the other coverage, no-fault or other automobile insurance or any other primary plan.

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 which, when added to the benefits payable by the other coverage, will not exceed reasonable charges. The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by

General Limitations *continued*

the National Association of Insurance Commissioners. 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 Plan 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. As a member of a prepaid plan, special limitations on your CHAMPUS coverage apply. To receive standard HMO benefits, your primary care provider must authorize all care; you may self-refer for eligible POS services. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage.

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 services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for services it provided 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

If a covered person is sick or injured as a result of the act or omission of another person or party, the Plan requires that it be reimbursed for the benefits provided in an amount not to exceed the amount of the recovery, or that it be subrogated to the person's rights to the extent of the benefits received under this Plan, including the right to bring suit in the person's name. If you need more information about subrogation, the plan will provide you with its subrogation

General Exclusions

All benefits are subject to the limitations and exclusions in this brochure. **Although a specific service may be listed as a benefit, it will not be covered for you unless your Plan doctor determines it is medically necessary to prevent, diagnose or treat your illness or condition as discussed under Authorizations on page 8.** The following are excluded:

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies (see Emergency Benefits) or eligible self-referral services obtained under Point of Service Benefits;
- Expenses incurred while not covered by this Plan;
- Services furnished or billed by a provider or facility barred from the FEHB Program;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Procedures, treatments, drugs or devices that are experimental or investigational;
- Procedures, services, drugs and supplies related to sex transformations; and
- Procedures, services, drugs and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest.

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; **you pay** a $5 office visit copay, but no additional copay for laboratory tests, x-rays and prenatal office visits. You pay nothing for well child care for children under 5 years of age. Within the service area, house calls will be provided if in the judgment of the Plan doctor such care is necessary and appropriate; **you pay** nothing for a doctor's house call; or home visits by nurses and health aides.

The following services are included and are subject to the office visit copay unless stated otherwise.

- Preventive care, including well-baby care and periodic check-ups (copay waived for well-child care for children under age 5)
- Vision and hearing screening when performed by a Plan primary care doctor; complete hearing exam only when referred by a Plan primary care doctor
- Mammograms are covered as follows: for women age 35 through age 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. Copays are waived for maternity care. 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. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child, when provided by a Plan doctor during the covered portion of the mother's hospital confinement for maternity, will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum). You pay nothing.
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints.
- Cornea, heart, heart-lung, kidney, liver, lung (single and double), pancreas, and pancreas-kidney transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, breast cancer, multiple myeloma, epithelial ovarian cancer, and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Transplants are covered when approved by the Plan Medical Director. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.
- 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.
- Dialysis; you pay nothing
- Chemotherapy and radiation therapy; you pay nothing
- Inhalation therapy
- Surgical treatment of morbid obesity
- Orthopedic devices, such as braces; foot orthotics, including replacement or adjustment limited to that necessitated by the member's physical changes or growth

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS TO RECEIVE STANDARD HMO BENEFITS

- Prosthetic devices, such as artificial limbs and lenses following cataract removal, including replacement or adjustment limited to that necessitated by the member's physical changes or growth
- Durable medical equipment, such as wheelchairs, hospital beds, glucometers and oxygen for home use, including equipment; you pay nothing.
- Home health services by nurses and home health aides, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need; you pay nothing.
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers.

Limited benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion, and any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome, except as defined on page 19.

Cleft lip and cleft palate benefits are provided for inpatient or outpatient expenses arising from: orthodontics; oral surgery; otologic, audiological, and speech/language treatment involved in one or both. You pay a $5 per office visit copay.

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient basis for up to two months per condition if significant improvement can be expected within two months; **you pay** nothing per session. **Short-term rehabilitative therapy** is provided on an outpatient basis; a combined benefit maximum for physical and occupational therapy is 90 visits per condition, per contract year; **you pay** $5 per visit. Speech therapy is covered for 90 visits, per condition, per contract year; you pay $5 per visit. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. Plan benefits are only available to the extent that the plan provider determines they can be expected to result in the improvement of a member's condition.

Diagnosis and treatment of infertility is covered. **You pay** $5 per office visit. The following type of artificial insemination is covered: Intracervical insemination (ICI); you pay $5 per visit. Cost of donor sperm is not covered. Fertility drugs are not covered. Other assisted reproductive technology (ART) procedures such as in vitro fertilization, embryo transfer and intrauterine insemination (IUI) are not covered.

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- Homemaker services
- Hearing aids
- Transplants not listed as covered
- Long-term rehabilitative therapy
- Cardiac rehabilitation
- Chiropractic services
- Organ donor related transportation expenses
- Acupuncture services

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS TO RECEIVE STANDARD HMO BENEFITS

Hospital/Extended Care Benefits

What is covered

Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. **You pay** nothing. **All necessary services are covered,** including:

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care
- Specialized care units, such as intensive care or cardiac care units
- Blood and blood derivatives

Extended care

The Plan provides a comprehensive range of benefits for up to 100 days each calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. **You pay** nothing. **All necessary services are covered,** including:

- Bed, board and general nursing care
- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor.

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 16 for nonmedical substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Custodial care, rest cures, domiciliary or convalescent care

Emergency Benefits

What is a medical emergency?

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

Emergencies within the service area

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan **must** be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers, except as covered under POS benefits.

Plan pays . . . Reasonable charges for emergency services to the extent the services would have been covered if received from Plan Providers.

You pay . . . $25 per hospital emergency room or urgent care center visit for emergency services which are covered benefits of this Plan. If the emergency results in admission to a hospital, the copay is waived.

Emergencies outside the service area

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan **must** be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers, except as covered under POS benefits.

Plan pays . . . Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

You pay . . . $25 per hospital emergency room or urgent care center visit for emergency services which are covered benefits of this Plan. If the emergency results in admission to a hospital, the copay is waived.

What is covered

- Emergency care at a doctor's office or an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- Ambulance service approved by the Plan

What is not covered

- Elective care or nonemergency care, except as covered under POS benefits
- Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area, except as covered under POS benefits
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area, except as covered under POS benefits

Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card. Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 24.

Mental Conditions/Substance Abuse Benefits

Mental conditions/ Substance abuse

Treatment for mental health conditions and substance abuse may be obtained by calling Green Spring Health Management Services (or other mental health administrator, as determined by the Plan); call Green Spring at 800/245-7013. Green Spring will determine all appropriate referrals to specialists and facilities.

What is covered

To the extent shown below, this Plan provides the following medically necessary services for the diagnosis and treatment of mental illness, or emotional disorder, drug abuse and alcohol abuse. This Plan provides medical and hospital services such as acute detoxification for the medical non-psychiatric aspects of drug abuse and alcohol abuse, under the same terms and conditions as for any other illness or condition. Outpatient visits to Plan mental health providers for follow-up care are covered, as well as inpatient services necessary for diagnosis and treatment.

- Diagnostic evaluation
- Psychological testing
- Psychiatric, drug abuse and alcohol abuse treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Outpatient Care

Unlimited outpatient visits to Plan doctors, consultants or other psychiatric personnel each calendar year; **you pay** $15 per visit for visits 1 through 5, $25 per visit for visits 6 through 30, $35 per visit thereafter for the remainder of the calendar year.

Inpatient Care

Up to 365 days of hospitalization each calendar year; **you pay** nothing

Partial Hospitalization

Up to 60 days of partial hospitalization each calendar year; **you pay** a $5 copay per day - all charges thereafter.

Medication Management

Unlimited visits to a Plan doctor each calendar year; you pay a $5 copay per visit

What is not covered

- Care for psychiatric, drug abuse and alcohol abuse conditions which in the professional judgment of Plan doctors are not treatable.
- Psychiatric, drug abuse and alcohol abuse evaluations or therapy on court order, or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate.
- Psychological testing that is not medically necessary to determine the appropriate treatment of a condition.
- Treatment which is not authorized by a Plan doctor

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 34-day supply; **you pay** a $5 copay per prescription unit or refill. Substitution of generic equivalents for name brand drugs will be made by Plan pharmacies, except when there is no generic equivalent of a name brand drug or when an equivalent is available but a Plan doctor specifies only a name brand is to be used.

You may be required to use pharmacies associated with your medical center. Call your center or primary care physician to determine which pharmacy must be used to fill your prescription.

Covered medications and accessories include:

- Drugs for which a prescription is required by law
- Dental prescriptions when written by a Plan dentist
- Oral and injectable contraceptive drugs; contraceptive diaphragms and devices
- Implanted contraceptive drugs, such as Norplant
- Insulin
- Disposable needles and syringes needed for injecting covered prescribed medication
- Intravenous fluids and medications for home use are covered under Medical and Surgical Benefits
- Diabetic supplies, including acetone test, alcohol swabs, blood glucose control regents, blood glucose test kit, glucose monitoring test supplies, insulin injection device, lancets, swabs and test strips; you pay nothing.

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available
- Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies
- Medical supplies such as dressings and antiseptics
- Vitamins and nutritional substances which can be purchased without a prescription
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Smoking cessation drugs and medication, including nicotine patches
- Fertility drugs

Other Benefits

Dental care

What is covered

The following list summarizes the dental services provided by participating Plan dentists and indicates copayments where they apply. This Plan covers other dental services at varying copayment levels that are not specifically listed below. For further information regarding these services and applicable copayment levels, please call (410) 512-4300 or 800/245-7006. All dental services must be provided by participating Plan dentists.

Schedule of Benefits

Code #	Description of Services	Copay
Clinical Oral Examinations		
00120	Periodic Oral Evaluation	$5
00140	Limited Oral Evaluation - Problem Focused	$5
00150	Comprehensive Oral Evaluation	$6
Radiographs		
00210	Intraoral - Complete Series (incl. Bitewings)	$11
00272	Bitewings - 2 Films	$ 5
00330	Panoramic X-Rays	$11
Dental Prophylaxis		
01110	Prophylaxis (Cleaning) - Adult (two per year)	$8
01120	Prophylaxis (Cleaning) - Child (two per year)	$6
Topical Fluoride Treatment		
01203	Topical App. Of Fluoride Tx - Child (exclude prophy)	$3
01204	Topical App. Of Fluoride Tx - Adult (exclude prophy)	$3
01351	Sealant - Per Tooth	$3
Amalgam Restorations (Including Local Anesthesia & Polishing)		
02110	Amalgam - one surface, primary	$27
02120	Amalgam - two surfaces, primary	$36
02130	Amalgam - three surfaces, primary	$49
02140	Amalgam - one surface, permanent	$27
02150	Amalgam - two surfaces, permanent	$36
02160	Amalgam - three surfaces, permanent	$49
Resin Restoration (Including Local Anesthesia)		
02330	Resin - one surface, anterior	$31
02331	Resin - two surfaces, anterior	$44
02332	Resin - three surfaces, anterior	$58
Complete Dentures (Including Routine Post-Del Care)		
05110	Complete maxillary denture	$399
05120	Complete mandibular denture	$399
05130	Immediate maxillary denture	$422
05140	Immediate mandibular denture	$422
Partial Denture (Including Routine Post-Del Care)		
05213	Max part dent resin base (incl. any conv. clasp/rests/teeth)	$482
05214	Mand part dent resin base (incl. any conv. clasps/rests/teeth)	$482
Adjustments to Removable Prosthesis		
05410	Adjust complete denture - maxillary	$14
05411	Adjust complete denture - mandibular	$15
05421	Adjust partial denture - maxillary	$18
05422	Adjust partial denture - mandibular	$18
Repairs to Partial Dentures		
05510	Repair broken complete denture base	$60

Code #	Description of Services	Copay
Extractions (Including Local Anesthesia and Routine Postoperative Care)		
07110	Single tooth	$ 31
07210	Surgical removal of erupted tooth requiring elevation of mucoperisteal flap	$ 44
07220	Removal of impacted tooth - soft tissue	$ 79
07230	Removal of impacted tooth - partially bony	$ 95
07240	Removal of impacted tooth - completely	$140
Orthodontics		
08070	Comprehensive - transitional	$2,025
08080	Comprehensive - adolescent	$2,025
08090	Comprehensive - adult	$2,025

- Members must select a participating provider site from which to receive care.
- Members may transfer participating provider sites if there is no outstanding balance at the site.
- Members must be referred to participating specialist sites by their participating provider site.
- Members are required to verify provider participation by calling Client Service before seeking care at any new provider site.

In the case of accident or emergency involving acute pain or a condition requiring immediate treatment (but not hospitalization), occurring more than fifty (50) miles from the subscriber's home, and received from non-Plan providers, the Dental Plan covers the cost of all necessary diagnostic and therapeutic dental procedures administered by a general dentist up to $50 for each accident or emergency, subject to the member's copayment.

Questions regarding plan benefits and features should be directed to Client Service, 410-512-4300 or 1-800-245-7006.

Accidental injury benefit

Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth are covered only when; the initiation of services is within 60 days of the accidental injury. Plan benefits for follow up care are limited to care rendered within one year of the date of the accidental injury. The need for these services must result from an accidental injury, and must be authorized by your primary care doctor. **You pay** $5 per visit.

What is not covered

- Orthognathic Surgery
- Dental services for which general anesthesia is required.
- Procedures considered to be cosmetic, elective, or investigative in nature are not covered.
- Other dental services not shown as covered.
- Orthodontic treatment in progress prior to the member's effective date of coverage under this Plan.
- Dental accidental injuries caused by chewing.

Vision care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, this Plan provides the following vision care benefits.

- Routine annual eye refraction, including written lens prescription for eyeglasses. You pay $5 per visit when the examination for annual eye refraction is received from a Plan provider.
- Per 24 month period, one pair of prescription lenses (single vision, bifocal or trifocal) and frames will be covered when selected from the designated Frame Display of a participating provider of Maryland Eye Care. **You pay** nothing. If lenses and frames are not selected from the designated Frame Display, the Plan will pay the maximum allowances to either the Plan provider or the optician of your choice for lenses and frames or contact lenses shown in the vision schedule listed below. **You pay** all charges in excess of the allowance shown. Please check with your chosen optician to determine if he or she is a Maryland Eye Care participating provider.

Lenses	**Frame**	**Plan's Total Allowance**
• Single Vision $41.50	$29.50	$ 71.00
• Bifocal ..... $ 67.00	$29.50	$ 96.50
• Trifocal ..... $ 89.50	$29.50	$119.00
• Cataract (aphakic) $156.50	$29.50	$186.00

Contact Lenses

- Medically required contact lenses $221.00
- Cosmetic (Member's choice in lieu of frames and lenses)
  - — Single Vision Lenses ..... $ 71.00
  - — Bifocal Lenses ..... $ 96.50

What is not covered

- Contact lens examinations and examinations for the fitting or dispensing of contact lenses
- Sunglasses

Point of Service Benefits

Facts about the FreeState Health Plan, New Choice (A self-referral program)

At your option, you may choose to obtain benefits covered by this Plan from non-Plan doctors and hospitals whenever you need care, **except** for the benefits listed below under "What is not eligible for self-referral." Benefits not covered under Point of Service Benefits must either be received from or arranged by Plan doctors to be covered. When you obtain covered non-emergency medical treatment from a non-Plan doctor without a referral from a Plan doctor, you are subject to the deductibles, coinsurance and maximum benefit stated below.

Members may self-refer for most services. Some services, shown below, must be referred by your primary care physician. For eligible self-referral services, the **Plan pays** 80% of the allowable benefit after **you pay** a $200 calendar year deductible for an individual, or $400 for a family. Expenses incurred in the last month of the calendar year, which are used to satisfy the deductible, will apply to the deductible of the following calendar year. **You pay** the deductible and 20% of the allowed benefit. If the actual charge for a covered service is more than the allowed benefit, you must also pay the difference.

Pre-authorization from the Plan is required for certain services, as shown below, when not of an emergency nature. You or your physician must call the Plan for authorization. If you do not call for authorization, you risk having to pay 40% of the allowed benefit after the deductible and take the chance that the procedure is not a covered benefit.

This Self-Referral Program has an out-of-pocket maximum based on deductible and coinsurance payments. Once out-of-pocket expenses for deductibles and coinsurance reach $2,000 per member or $4,000 per family, the Plan will pay 100% of the allowed benefit for the remainder of the calendar year. Coinsurance amounts for failure to obtain preauthorization do not contribute toward the out-of-pocket maximum.

Although self-referral benefits are available for some services, you should remember that the out-of-pocket costs are lower through the standard HMO benefit.

An allowed benefit is the acceptable charge that the Plan uses to calculate the reimbursement to a health care provider that is not under contract with the Plan. The member is responsible for any amount that exceeds the allowed benefit determined by the Plan, plus the stated coinsurance payment.

Benefits under the Self-Referral Program are subject to the definitions, limitations and exclusions shown elsewhere in this brochure. The Plan determines the medical necessity of services and supplies provided to prevent, diagnose or treat an illness or condition.

Medical and surgical benefits

What is eligible for self-referral

At your option, you can choose to self-refer for the following services instead of getting a referral from your primary care physician. **You pay** 20% of the allowed benefit after the deductible.

- Physician office, home or hospital visits
- Specialist care and consultation
- Allergy testing and treatment
- Maternity, annual pap smears and pelvic exams
- Diagnostic laboratory and x-ray tests
- Surgical procedures (pre-authorization required)
- Periodic physical exams, immunizations and well child care
- Physical, speech or occupational therapy
- Home health care (pre-authorization required)
- Durable medical equipment, prosthetics and orthopedic devices (pre-authorization required)
- Hearing and vision exams
- Family planning and sterilizations
- Dialysis, chemotherapy, radiation therapy and inhalation therapy
- Infertility services (pre-authorization required)

Point of Service Benefits *continued*

What is not eligible for self-referral

The following services must be provided by or referred to specialists by your primary care physician or the Plan. You cannot self-refer for the following services:

- Health education services
- Dental care benefits
- Emergency and urgent care benefits

Hospital/extended care benefits

What is eligible for self-referral

You can choose to be admitted for an inpatient hospital stay through self-referral. You must notify the Plan in advance of any self-referral admission and the admission must be preauthorized by the Plan. **You pay** 20% and any charges above the allowed benefit after the $200 deductible is satisfied. If preauthorization is not obtained, you pay 40% of the allowed benefit after the deductible. To obtain preauthorization call (410) 528-7029 or 800/898-9903. In addition to the services noted above, the following require preauthorization.

- Inpatient hospitalization
- Skilled nursing facility
- Hospice care

Mental conditions/ substance abuse benefits

What is eligible for Point of Service benefits

You can choose to self refer for inpatient hospital and outpatient care. You must call the Plan to obtain a preauthorization prior to receiving any self-referral services. **You pay** 20% and any charges above the allowed benefit, after the deductible is satisfied, for all covered services except out patient care. Outpatient care will be covered, after the deductible. You pay 20% of the allowed benefit and any charges above the allowed benefit per visit for visits 1 through 5; **you pay** 35% of the allowed benefit and any charges above the allowed benefit per visit for visits 6 through 30; **you pay** 50% of the allowed benefit and any charges above the allowed benefit per visit thereafter for the remainder of the calendar year.

If preauthorization is not obtained for inpatient care, **you pay** 40% of the allowed charges, after the deductible. To obtain preauthorization of inpatient or outpatient care call 1-800-245-7013.

Emergency care

What is eligible for self-referral

Emergency services will be treated as a standard HMO benefit and only provided through the HMO delivery system. Please refer to the section in this brochure covering emergency benefits.

Other covered benefits

What is eligible for self-referral

Prescriptions written as a result of a self-referral to a doctor are eligible for a $5 copayment for a 34-day supply as long as they are filled at a Plan participating pharmacy. If a non-participating pharmacy is used, **you pay** 20% of the allowed benefit after the deductible, and any cost in excess of the allowed benefit.

How to file claims

Call the Client Services Department at 410/654-8675 or 800/445-6036 for claim forms and submit your claims to:

CFS Health Group, Inc.
FEP New Choice Claims
P.O. Box 308
Owings Mills, MD 21117-0308

Non-FEHB Benefits Available to Plan Members

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

Expanded dental benefits

Freestanding non-group dental coverage—Just Dental High Option. You must enroll in Just Dental High Option during the same time that the FEHB Open Season is going on.

This freestanding product offering means that even though Just Dental High Option is available through FreeState Health Plan Inc., you do not need to enroll in FreeState's FEHB Health Plan to benefit from Just Dental High Option's comprehensive services. Just Dental High Option is a truly stand-alone plan; your enrollment will be independent of your FEHB Health Plan enrollment.

You will benefit from **attractive discounts** on all types of dental procedures—from office visits and routine cleanings to lab and x-ray services and specialty care.

For more information, please call Just Dental at **800/245-7006** or **410/512-4300.** Upon request, we will promptly send to you a pamphlet including specific enrollment procedures, dental services and fees, participating providers and an application form.

Please keep in mind that your application for enrollment requires your annual prepayment for the first twelve-month coverage period (you will have the option to renew your Just Dental coverage thereafter).

The 1999 **Annual Premiums** for Just Dental High Option are:

Individual:	$153.00
Parent/Child:	$229.00
Husband/Wife:	$265.00
Family:	$385.00

Expanded vision care

Any FreeState Health Plan, Inc. member utilizing a MEC Health Care provider will receive a 20% discount on lenses, frames or contacts if purchased through this Plan provider.

Medicare Prepaid Plan

Medicare prepaid plan enrollment - This Plan offers Medicare recipients the opportunity to enroll in a Plan through Medicare. As indicated on page 4, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those **without** Medicare Part A may join this Medicare prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. **Before** you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at (410) 356-8123 or (800) 275-3802 for information on the Medicare prepaid Plan and the cost of that enrollment.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by the Plan without dropping your enrollment in this Plan's FEHB plan, call (410) 356-8123 or 1-(800) 275-3802 for information on the benefits available under the Medicare HMO.

Benefits on this page are not part of the FEHB contract

How to Obtain Benefits

Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Member Services Department at (410) 654-8675, 800/445-6036, (410) 998-5768 TDD, 800/828-3196 TDD, or you may write to the Plan at BCBSM/FreeState Health Plan, 10455 Mill Run Circle, 01-780, Owings Mills, MD 21117. You may also contact the Plan by fax at 410/998-5809.

Disputed claims review

Plan reconsideration

If a claim for payment or services is denied by the Plan, you must ask the Plan, in writing and within six months of the date of the denial, to reconsider its denial before you request a review by OPM. (This time 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 Plan an opportunity to reconsider your claim. Your written request to the Plan must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided.

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

OPM review

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

You may also ask OPM for a review if the Plan fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Plan. In this case, OPM must receive a request for review within 120 days of your request to the Plan for reconsideration or of the date you were notified that the Plan 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 denied claim for payment or service should have been paid or provided. If the Plan 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 Plan requesting reconsideration;
- A copy of the Plan's reconsideration decision (if the Plan failed to respond, provide instead (a) the date of your request to the Plan or (b) the dates the Plan requested and you provided additional information to the Plan);
- Copies of documents that support your claim (such as doctors' letters, operative reports, bills, medical records, and explanation of benefit (EOB) forms); and
- Your daytime phone number.

Medical documentation received from you or the Plan 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 3, P.O. Box 436, Washington, DC 20044.

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

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Plan'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 Plan has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Plan in support of OPM's decision on the disputed claim.

How FreeState Health Plan Changes January 1999

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

Program-wide Changes:

- Several changes have been made to comply with the President's mandate to implement the recommendations of the Patient Bill of Rights.
- If you have a chronic, complex, or serious medical condition that causes you to frequently see a Plan specialist, your primary care doctor will develop a treatment plan with you and your health plan that allows an adequate number of direct access visits with that specialist, without the need to obtain further referrals. See page 8 for details.
- A medical emergency is defined as the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. See page 15.
- The medical management of mental conditions is covered under this Plan's Medical and Surgical Benefits provisions. Related drug costs will be covered under this Plan's Prescription Drug Benefits, and any costs for psychological testing or psychotherapy will be covered under this Plan's Mental Conditions Benefits.

Changes for FreeState Members

- Women may see their Plan gynecologist for their annual routine examination without a referral from their primary care doctor. See page 7.
- Under "Medical and Surgical Benefits" provision, the copay is now waived for chemotherapy and radiation therapy treatments. Previously, a $5 copay, per visit applied. See page 12.
- Under "Medical and Surgical Benefits" provision, the copay is now waived for dialysis treatments. Previously, a $5 copay applied. See page 12.
- Under "Limited Benefits" in the "Medical and Surgical" provision, outpatient physical and occupational therapy is a combined maximum of 90 visits, per condition, per calendar year, subject to a $5 copay per visit. Speech therapy is covered for 90 visits, per condition, per calendar year, subject to a $5 copay per visit. Previously, rehabilitative therapy was subject to 90 days per condition, subject to a $5 copay per visit. See page 13.
- Under " Medical and Surgical" provision, the copay is now waived for allergy tests and treatments. Previously, a $5 copay applied. See page 12.
- Under "Prescription Drug Benefits" provision, certain diabetic supplies are covered in full. Previously, diabetic supplies were not covered under prescription drug benefits. See page 17.
- Under "Dental Care" in the "Accidental injury" provision, limitations are described for dental services resulting from an accidental injury. Previously, limitations were not shown. See page 19.
- Under "Medical and Surgical Benefits" provision, home visits by nurses and health aides are covered in full. Previously, a $10 copay, per visit applied. See page 12.
- Under "Point of Service Benefits" in the "Medical and Surgical Benefits" provision, infertility services are now shown as covered. See page 21.
- Under "Facts about this Plan" in the "Plan's service area" provision, you must live or work in the service area to enroll in this Plan. Previously, to enroll in this Plan, you had to live in the service area. See page 9.
- The Plan's service area has been expanded to include the District of Columbia. See page 9.

Changes for CareFirst Members

- Under "Prescription Drug Benefits", the copay for prescription drugs has been increased to $5 per prescription unit or refill. Previously, a $3 copay applied per prescription or refill. See page 17.
- Under "Hospital/Extended Care Benefits" provision, coverage for extended care is limited to 100 days, per calendar year. Previously, extended care days were unlimited. See page 14.

How FreeState Health Plan Changes January 1999 *continued*

- Under "Medical and Surgical Benefits" provision, voluntary surgical sterilizations are subject to a $5 copay. Previously, a $50 copay applied. See page 12.
- Under "Medical and Surgical Benefits" provision, well child care for children under 5 years of age is covered in full. Previously, a $5 copay per visit applied. See page 12.
- Under "Medical and Surgical Benefits" provision, xray services are covered in full. Previously, a $5 copay applied. See page 12.
- Under "Medical and Surgical Benefits" provision, allergy tests and treatments are covered in full. Previously, a $15 copay applied to allergy tests and a $5 copay applied to allergy treatments. See page 12.
- A " Point of Service Benefits" provision that allow you to obtain benefits covered by this Plan from non-Plan doctors is now available to former members of CareFirst HMO. Previously, point of service benefits were not available to CareFirst HMO members. See pages 21–22.
- Under "Medical and Surgical Benefits" provision, laboratory tests are covered in full. Previously, a $5 copay applied. See page 12.
- Under "Medical and Surgical Benefits" provision, home health visits by a physician, nurse or health aide are covered in full. Previously, a $10 copay applied. See page 13.
- Under "Medical and Surgical Benefits" in the "Limited Benefits" provision, physical and occupational therapy is a combined maximum of 90 visits, per condition, per calendar year, subject to a $5 copay per visit. Speech therapy is covered for 90 visits, per condition, per calendar year, subject to a $5 copay per visit. Previously, these services were covered in full, for up to two months, per condition. See page 13.
- Under "Other Benefits" in the "Dental Care" provision, copayments for dental services have changed. Previously, the copayments were slightly higher. See pages 18–19.
- Under "Other Benefits" in the "Vision Care" provision, eyewear and contact lenses are covered. Previously, eyewear and contact lenses were not covered. See page 20.
- Under "Facts about this Plan" under "The Plan's service Area" provision, you must live or work in the service area to enroll in this Plan. Previously, to enroll in this Plan, you had to live in the service area. See page 9.

Changes for Columbia Medical Plan Members

- Under " Prescription Drug Benefits" in the "What is not covered" provision, fertility drugs are not covered. Previously, fertility drugs were covered. This means that if you are currently receiving fertility drug treatments, these treatments will not be covered effective January 1, 1999. See page 17.
- Under "Medical and Surgical Benefits" provision, the copay is now waived for x-ray services. Previously, a $5 copay applied. See page 12.
- Under "Medical and Surgical Benefits" provision, the copay is now waived for laboratory tests. Previously, a $5 copay applied. See page 12.
- Under "Medical and Surgical Benefits" provision, durable medical equipment is covered in full. Previously, coverage for durable medical equipment was; 50% of covered charges, up to a maximum of $2,500 per member, per calendar year and a lifetime benefit of $2,500 per any single piece of equipment. See page 13.
- Under "Other Benefits" in the "Dental Care" provision, copayments for dental services have changed Previously, the copayments were slightly higher. See pages 18–19.
- Under "Medical and Surgical Benefits" provision, the copay is now waived for home visits by a physician, nurse or health aide. Previously, a $5 copay applied to these services. See page 12.
- Under "Medical and Surgical Benefits" provision, the copay is now waived for allergy testing and treatments. Previously, a $5 copay applied to these services. See page 12.

How FreeState Health Plan Changes January 1999 *continued*

- Under “Medical and Surgical Benefits” in the “Limited Benefits” provision, physical and occupational therapy is a combined maximum of 90 visits, per condition, per calendar year, subject to a $5 copay, per visit. Speech therapy is covered for 90 visits, per condition, per calendar year, subject to a $5 copay per visit. Previously, these services were covered up to 30 visits or 90 days (whichever is greater) per condition, subject to a $5 copay per visit. See page 13.

- Under “Point of Service” provision, the calendar year deductible, is now $200 per individual and $400 per family. Previously, the calendar year deductible was $250 per individual and $450 per family. See page 21.

- Under “Point of Service Benefits” provision, the out of pocket maximums are $2,000 per individual and $4,000 per family, per calendar year. Previously, the out of pocket maximums were $2,500 per individual and $5,000 per family, per calendar year. See page 21.

- Under “Point of Service Benefits” in the “What is eligible for self referral” provision, infertility services are covered. Previously, infertility services were not covered under POS. See page 21.

Notes

Notes

Summary of Benefits for FreeState Health Plan, Inc. — 1999

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the 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 SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, AND SERVICES AVAILABLE AS POS BENEFITS, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.**

	Benefits	Plan pays/provides	Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** nothing	**14**
	Extended care	All necessary services, up to 100 days per calendar year. **You pay** nothing	**14**
	Mental conditions and substance abuse	Diagnosis and treatment of acute psychiatric conditions for up to 365 days of inpatient care per year. **You pay** nothing	**16**
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. You pay $5 per office visit; nothing per house call by a doctor. You pay nothing for prenatal care and well child care for children under age 5	**12**
	Home health care	All necessary visits by nurses and health aides. You pay nothing	**12**
	Mental conditions and substance abuse	Unlimited outpatient visits per year. You pay a $15 copay per visit for visits 1 - 5; a $25 copay per visit for visits 6 - 30; and a $35 copay per visit thereafter for the remainder of the year.	**16**
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $25 copay to the hospital or urgent care center for each emergency room visit and any charges for services that are not covered benefits of this Plan	**15**
Prescription drugs		Drugs prescribed by a Plan doctor or Plan dentist and obtained at a Plan pharmacy. **You pay** a $5 copay per prescription unit or refill	**17**
Dental care		Accidental injury benefit; you pay a $5 copay per visit. Preventive dental care; **you pay** variable copays for most services	**18–19**
Vision care		One refraction annually. **You pay** a $5 copay per visit.	**20**
Point of Service		Services of out-of-network doctors and hospitals. Not all benefits are covered. **You pay** deductibles and coinsurance and a maximum benefit applies. After your coinsurance and deductible expenses reach a maximum of $2,000 per Self or $4,000 per Self and Family enrollment per calendar year, covered benefits will be provided at 100% of the allowed benefit for the remainder of the calendar year. Coinsurance amounts for failure to obtain pre-authorization do not contribute toward the out-of-pocket maximum.	**21–22**
Out-of-pocket limit		Your out-of-pocket expenses for benefits covered under this Plan and authorized by Plan providers are limited to the stated copayments which are required for a few benefits.	**8**

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United States Office of Personnel Management

Federal Employees Health Benefits Program

1999 Rate Information for FreeState Health Plan

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

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

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	**LD1**	**$ 71.61**	**$23.87**	**$155.15**	**$ 51.72**	**$ 84.74**	**$10.74**
Self and Family	**LD2**	**$160.39**	**$86.10**	**$347.51**	**$186.55**	**$183.29**	**$63.20**