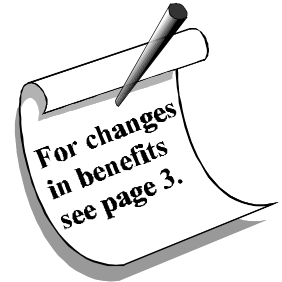
APWU Health Plan 2000

A Managed Fee-for-Service Plan
with Preferred Provider Organizations and a Point of Service Product
Sponsored by the American Postal Workers Union, AFL-CIO



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

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

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

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

Enrollment code for this Plan:
471 Self only
472 Self and family

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

Authorized for distribution by the:

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Introduction

APWU Health Plan
12345 New Columbia Pike
Silver Spring, Maryland 20904

This brochure describes the benefits you can receive from APWU Health Plan under its contract CS1370 with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This Plan is underwritten by the American Postal Workers Union, AFL-CIO.

This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. Nothing anyone says can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

Because OPM negotiates benefits and premiums annually, they change each year. This brochure describes the only benefits available to you under this Plan in 2000. Benefit changes are effective January 1, 2000, and are shown on page 3. You do not have a right to benefits that were available before January 1, 2000 unless those benefits are also contained in this brochure. Premiums are listed at the end of this brochure.

Plain language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to APWU Health Plan as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

Sections one, two, four, and ten are now in plain language, as well as portions of sections three and eight. We will rewrite the remaining sections of this brochure, including the benefits section, for year 2001. Please note that the format and organization of this brochure have changed as well.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

How to use this brochure

This brochure has ten sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. Fee-for-Service Plan (FFS). This Plan is a FFS Plan. Turn to this section for a brief description of Fee-for-Service plans and how they work.

2. How we change for 2000. If you are a current member and want to see how we have changed, read this section.

3. How to get benefits. Make sure you read this section; it tells you how to get benefits and how we operate.

4. What if we deny your claim or request for pre-authorization. This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.

5. Benefits. Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.

6. How to file a claim. Look here to find specific information on how to file claims with us.

7. General exclusions – Things we don't cover. Look here to see benefits that we will not provide.

8. Limitations – Rules that affect your benefits. This section describes limits that can affect your benefits.

9. Fee-for-Service Facts. This section contains information about pre-certification, protection against catastrophic expenses, and a definition section.

10. FEHB facts. Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Fee-for-Service Plans

Fee-for-service plans reimburse you or your provider for covered services. They do not typically provide or arrange for health care. Fee-for-service plans let you choose your own physicians, hospitals, and other health care providers.

The FFS plan reimburses you for your health care expenses, usually on a percentage basis. These percentages, as well as deductibles, methods for applying deductibles to families, and the percentage of coinsurance you must pay vary by plan. The type and extent of covered services varies by plan. There is a detailed explanation of the benefits we offer in this brochure; you should read it carefully.

This FFS plan offers a preferred provider organization (PPO) arrangement. This arrangement with health care providers gives you enhanced benefits or limits your out-of-pocket expenses.

Section 2. How we change for 2000

Program-wide changes

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition or are in the second or third trimester of pregnancy, and your provider is leaving our PPO network at our request without cause, we will notify you. You may continue to receive our PPO level benefits for your specialist's services for up to 90 days after you receive notice. We will provide regular non-PPO benefits for the specialist's services after the 90 day period expires.

You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.

If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to this Plan

- A Point of Service (POS) program is now available to members in certain counties in the State of Texas and in the Minneapolis/St. Paul, Minnesota areas. The program provides a higher level of benefits for services provided by or at the referral of the patient's selected primary care physician. Details of this program are available by contacting the Plan.
- The Plan now uses a smaller retail pharmacy network which will reduce the total number of participating pharmacies available and, in some cases, will eliminate the participation of certain pharmacy companies from the Plan's network. When filling prescriptions, Plan members should first confirm their pharmacy's continued participation in the Plan's network.
- For prescription drugs, enrollees who have Medicare Parts A and B as their primary payer will now pay a $5 copayment for each generic drug and a $15 copayment for each brand name drug obtained through the Plan's Mail order program.
- Your share of the Postal A premium will increase by 7.2% for Self Only or decrease by 5.3% for Self and Family.
- Your share of the Postal B premium will increase by 6.3% for Self Only or 6.8% for Self and Family.
- Your share of the Non-Postal premium will increase by 8.2% for Self Only or 7.5% for Self and Family.
- The brochure has been clarified to show that weight reduction/control and treatment of obesity are not covered whether or not caused by an organic condition. Only recognized surgery for morbid obesity is covered subject to prior Plan approval.
- The brochure has been clarified to show that specified deductibles and coinsurance will be waived when Medicare is primary only for services and supplies which are considered covered expenses of this Plan.
- The Plan now recognizes audiologists as covered providers for covered services performed within the scope of their license.

Section 3. How to get benefits

How do I keep my health care expenses down?

You can help

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

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

Precertification

Precertification evaluates the medical necessity of proposed admissions and the number of hospital days required to treat your condition. You are responsible for ensuring that the precertification requirement is met. You or your doctor must check with your Plan before being admitted to the hospital. If that doesn't happen, your Plan will reduce benefits by $500. Be a responsible consumer. Be aware of your Plan's cost containment provisions. You can avoid penalties and help keep premiums under control by following the procedures specified on page 33 of this brochure.

Flexible benefits option

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

PPO

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

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

POS

This Plan offers a Point of Service (POS) program in certain counties in Texas and in the Minneapolis/St. Paul, Minnesota service areas. The POS program offers a higher level of benefits when services are provided or referred by a participating primary care physician selected by the member, or non-PPO benefits for services received without a referral. An addendum and a POS selection form that outline benefit levels and special requirements of the POS program are available by calling the APWU Health Plan at 1-800/222-APWU.

How much do I pay for services?

You must share the cost of some services. These cost sharing measures include deductibles, coinsurance and copayments. These and other measures are described in more detail below.

Deductibles

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

How much do I pay for services? *(continued)*

Calendar year

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

Hospital admission

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

Prescription drugs

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

Mental conditions/Substance abuse

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

Carryover

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

Family limit

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

Coinsurance

Coinsurance is the stated percentage of covered charges you must pay after you have met any applicable deductible. The Plan will base this percentage on either the billed charge or the reasonable and customary charge, whichever is less. For instance, when a plan pays 70 percent of reasonable and customary charges for a covered service, you are responsible for 30 percent of the reasonable and customary charges, i.e., the coinsurance. In addition, you may be responsible for any excess charge over the Plan's reasonable and customary allowance. For example, if the provider ordinarily charges $100 for a service but the Plan's reasonable and customary allowance is $95, the Plan will pay 70 percent of the allowance ($66.50). You must pay the 30 percent coinsurance ($28.50), plus the difference between the actual charge and the reasonable and customary allowance ($5), for a total member responsibility of $33.50. Remember, if you use preferred providers, your share of covered charges (after meeting any deductible) is limited to the stated coinsurance amount.

When hospital charges are limited by law

When inpatient claims are paid according to a Diagnostic Related Group (DRG) limit (for instance, for admissions of certain retirees who do not have Medicare - see page 31), the Plan will pay 30 percent of the total covered amount as room and board charges and 70 percent as other charges and will apply your coinsurance accordingly.

How much do I pay for services? *(continued)*

Copayments

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

If provider waives your share

If a provider routinely waives (does not require you to pay) your share of the charge for services rendered, the Plan is not obligated to pay the full percentage of the amount of the provider's original charge it would otherwise have paid. A provider or supplier who routinely waives coinsurance, copayments or deductibles is misstating the actual charge. This practice may be in violation of the law. The Plan will base its percentage on the fee actually charged. For example, if the provider ordinarily charges $100 for a service but routinely waives the 30% coinsurance, the actual charge is $70. The Plan will pay $49 (70% of the actual charge of $70).

Lifetime maximums

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

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

Do I have to submit claims?

You usually do not have to submit claims to us, if you use preferred providers. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Please see section 6, How to file a claim, for specific information you need to know before you file a claim with us.

Who provides my health care?

In a Fee-for-Service Plan, you may choose any covered facility or provider.

Covered facilities

Freestanding ambulatory facility

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

Hospital

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

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

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

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

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

Who provides my health care? *(continued)*

Covered providers

For purposes of this Plan, covered providers include:

1) Doctor - A licensed doctor of medicine (M.D.), a licensed doctor of osteopathy (D.O.), a licensed doctor of podiatry (D.P.M.), or, for certain specified services covered by this Plan, a licensed dentist, licensed chiropractor, or licensed clinical psychologist practicing within the scope of the license.

2) Alternate Provider - Alternate providers are covered when performing certain specified services covered by this Plan and when such treatment is within the scope of the provider's license. Alternate providers are limited to licensed physical, occupational and speech therapists; licensed physician's assistants; Registered Nurses (R.N.); Licensed Practical Nurses (L.P.N.); Licensed Vocational Nurses (L.V.N.); and Certified Registered Nurse Anesthetists (C.R.N.A.).

3) Other covered providers include a qualified clinical psychologist, clinical social worker, optometrist, audiologist, nurse midwife, nurse practitioner/clinical specialist, and nursing school administered clinic. For purposes of this FEHB brochure, the term "doctor" includes all of these providers when the services are performed within the scope of their license or certification.

Coverage in medically underserved areas

Within States designated as medically underserved areas, any licensed medical practitioner will be treated as a covered provider for any covered services performed within the scope of that license. For 2000, the States designated as medically underserved are: Alabama, Idaho, Kentucky, Louisiana, Mississippi, Missouri, New Mexico, North Dakota, South Carolina, South Dakota, Utah and Wyoming.

PPO arrangements

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

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

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

When you use a PPO hospital, keep in mind that the professionals who provide services to you in the hospital, such as radiologists, anesthesiologists and pathologists, may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers. Also, use of a PPO facility does not necessarily increase the likelihood that you will be referred to other facilities or health professionals in the network. It is your responsibility to confirm the network participation of a facility or provider prior to obtaining services.

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

This Plan's PPO

The Plan has established a network of doctors and hospitals that have agreed to reduce their charges to members who voluntarily seek them out for covered services. If you are admitted to a PPO hospital, the Plan will pay 90% of covered Inpatient hospital charges. Precertification of all hospital admissions is still required as outlined on page 33. If you use the services of a PPO doctor, the Plan will pay in full after a $15 copayment for outpatient visits and pay 90% of other negotiated fees for covered services.

Who provides my health care? *(continued)*

Enrollees who reside in a PPO area will receive information concerning the PPO in their region. Additional locations may become available throughout 2000. If you need assistance in identifying a participating provider, call the Plan's PPO administrator for your state: Alliance PPO, Inc. 1-800/342-3289 for providers in the District of Columbia, Maryland, Virginia and West Virginia; Beech Street 1-800/923-3248 for providers in California, Florida, Georgia, Ohio, Oklahoma, Tennessee, Texas and Washington; MultiPlan 1-800/672-2140 for providers in New Jersey and New York; MedNet 1-800/556-1144 for providers in Maine; PreferredOne 1-800/451-9597 for providers in Minnesota; or First Health 1-800/447-1704 for all other states. For mental conditions/substance abuse providers (all states), call ValueOptions toll-free 1-888/700-7965. Including a provider in the PPO does not represent a warranty of services by the Plan nor does it constitute medical advice. When you phone for an appointment, please remember to verify that the physician is still a PPO provider.

What do I do if I'm in the hospital when I join this Plan?

First, call our customer service department at 1-800/222-APWU. If you are new to the FEHB Program, we will reimburse your covered expenses**.** If you are currently in the FEHB Program and are switching to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center, or
- You exhaust the benefits available from your former plan, or
- The 92nd day after you became a member of this Plan; whichever happens first.

These provisions only apply to the person who is hospitalized.

What if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. If it is, you may be able to continue seeing your provider for up to 90 days after you receive notice that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

If you continue seeing your specialist or OB/GYN under these conditions, your cost will be no more than you would normally pay for the services covered.

How do you decide if a service is experimental or investigational?

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

Definition of experimental or investigational

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

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

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

Section 4. What if we deny your claim or request for pre-authorization

What should I do before filing a disputed claim?

Before you ask us to reconsider your claim, you should first check with your provider or facility to be sure that the claim was filed correctly. For instance, did the provider use the correct procedure code for the services performed (surgery, laboratory test, X-ray, office visit, etc.)? Have your provider indicate any complications of any surgical procedures performed. Your provider should also include copies of an operative or procedure report, or other documentation that supports your claim.

If we deny your request for pre-authorization or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing;
2. Refer to specific brochure wording explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;
2. Pay the claim;
3. Approve your request for pre-authorization; or
4. Ask for more information

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

What if I have a serious or life threatening condition and you haven't responded to my request for pre-authorization?

Call us (1-800/222-APWU) and we will expedite our review.

What if you have denied my request for care and my condition is serious or life threatening?

If we expedite your review due to a serious medical condition and deny your request, we will inform OPM so that they can give your request expedited treatment too. Alternatively, you can call OPM's health benefits Contract Division II at 202/606-3818 between 8 a.m. and 5 p.m. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal. You may also ask OPM to review your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.

2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What do I send to OPM?

Your request must be complete, or OPM will return it to you. You must send the following information:

1. A statement about why you believe our decision is wrong, based on specific benefit provisions in this brochure;
2. Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
3. Copies of all letters you sent us about the claim;
4. Copies of all letters we sent you about the claim; and
5. Your daytime phone number and the best time to call.

If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;
2. The estate of a person once enrolled in the Plan; and
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

Where should I mail my disputed claim to OPM?

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

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our decision, your only recourse is to sue.

If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services or supplies.

What laws apply if I file a lawsuit?

Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5. Benefits

Inpatient Hospital Benefits

What is covered

The Plan pays for inpatient hospital services as shown below.

Precertification

The medical necessity of your hospital admission **must** be precertified for you to receive full Plan benefits. Emergency admissions not precertified must be reported within 48 hours of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See pages 33 and 34 for details.

Waiver

This precertification requirement does not apply to persons whose primary coverage is another health insurance policy or when the hospital admission is outside the United States and Puerto Rico. Also, this requirement generally does not apply to persons whose primary coverage is Medicare Part A, however, see page 33 for exceptions. For information on when Medicare is primary, see pages 28, 29 and 30.

Room and board

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

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

PPO benefit

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

Non-PPO benefit

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

Private room

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

Related benefits

Pre-surgical testing

Outpatient laboratory tests, pathology, radiology and X-rays related to surgery are paid as Other Medical Benefits (see pages 17, 18 and 19).

Professional charges

Charges for professional services of a doctor, alternate provider or anesthesiologist, even though billed by a hospital as part of hospital services, are covered only as shown on pages 12, 13, 14, 17 and 19.

Take-home items

Appliances, medical equipment and medical supplies that are provided for use outside a hospital are covered as Other Medical Benefits as shown on page 17.

Prescription drugs and medicines dispensed for take-home use are covered as Prescription Drugs as shown on pages 20, 21 and 22.

Inpatient Hospital Benefits *continued*

Hospitalization for dental work

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

What is not covered

- A hospital admission that the Carrier determines is not medically appropriate, i.e., the medical services did not require the acute hospital inpatient (overnight) setting, but could have been provided in a doctor's office, the outpatient department of a hospital, or some other less expensive setting without adversely affecting the patient's condition or the quality of medical care.
- Custodial care as defined on page 35.
- Day and evening care centers, nursing homes, skilled nursing facilities, extended care and residential treatment facilities, a place for rest or for the aged, or any other place which does not meet the definition of a hospital as shown on page 6.
- Services of a private duty nurse that would normally be provided by hospital nursing staff.
- Personal comfort items such as radio, television, air conditioners, beauty and barber services, guest meals and beds.

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

Surgical Benefits

What is covered

The Plan pays for the following services:

PPO benefit

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

Non-PPO benefit

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

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

- Charges of a surgeon. Charges for normal postoperative care by the surgeon(s) are considered to be part of the surgical charges.
- Charges of an anesthesiologist.
- Voluntary sterilization procedures.
- Routine circumcision of newborn.
- Breast reconstruction surgery following a mastectomy, including surgery to produce a symmetrical appearance on the other breast. Benefits will be provided for all stages of breast reconstruction following a mastectomy, including treatment of any physical complications, including lymphedemas, and for breast prostheses, including surgical bras and replacements (see also Other Medical Benefits on page 17).
- Recognized surgery for morbid obesity and organic impotence **(only with prior Plan approval.)** To obtain prior Plan approval, call Spectera/CARE Programs at 1-800/580-8771.
- Cosmetic surgery only if necessary:
  - for the correction of congenital defects which existed at or from birth (limited to conditions listed on page 35); or
  - for repair of injuries caused by an accident provided the surgery is completed within two years of the accidental injury.

Multiple surgical procedures

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

Surgical Benefits *continued*

Incidental procedures

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

Assistant surgeon (inpatient/ outpatient)

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

Second opinion (voluntary)

See Other Medical Benefits (page 17).

Anesthesia

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

Organ/tissue transplants and donor expenses

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

Prior approval

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

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

PPO benefit

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

Non-PPO benefit

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

What is covered

Benefits will be provided for the following transplants:

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

What is not covered

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

Surgical Benefits *continued*

Oral and maxillofacial surgery

This Plan will pay reasonable and customary charges in or out of a hospital, to the extent shown on page 12, only for:

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

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

Mastectomy Surgery

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

Pre-surgical testing

Outpatient laboratory tests, pathology, radiology and X-rays related to surgery are paid as Other Medical Benefits (see page 17).

What is not covered

- Cosmetic surgery and other related expenses, except as described on page 12.
- Sterilization reversal.
- Trimming of toenails or removal of corns and calluses**, except when the patient is under active treatment of metabolic or peripheral vascular disease.
- Eye surgery, such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).
- Dental bridges, replacement of natural teeth, dental/orthodontic/temporomandibular joint dysfunction appliances and any related expenses.
- Treatment of periodontal disease and gingival tissues, and abscesses.
- Charges related to orthodontic treatment.
- Oral implants or transplants of any kind.

**May be eligible for Wellness benefit (see page 20).

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

Maternity Benefits

What is covered

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

Maternity Benefits *continued*

Inpatient hospital

Precertification

The medical necessity of your hospital admission must be precertified for you to receive full Plan benefits. Unscheduled or emergency admissions not precertified must be reported within 48 hours of admission even if you have been discharged. Newborn confinements that extend beyond the mother's discharge must also be precertified. If any of the above are not done, the benefits payable will be reduced by $500. See pages 33 and 34 for details.

Waiver

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

Room and board and Other charges

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

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

PPO benefit

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

Non-PPO benefit

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

Private room

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

Bassinet and nursery

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

Outpatient care

Outpatient hospital care for surgery (delivery) including care in freestanding ambulatory facilities, including birthing centers, is covered as described under Other Medical Benefits on page 18.

Obstetrical care

- Delivery (paid under Surgical Benefits as shown on page 12), including prenatal and postpartum care (paid as shown on page 17).
- Administration of anesthesia, as shown on page 13.
- Services of a licensed midwife.

Tests

Sonograms, amniocentesis (but not for diagnosing multiple births) and other related diagnostic services which are accepted medical practice, paid as shown on page 17.

Related benefits

Contraceptive devices and drugs

See Other Medical Benefits on page 17 and Prescription Drugs on page 20.

Diagnosis and treatment of infertility

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

Voluntary sterilization

See Surgical Benefits on page 12.

Well child care

See Additional Benefits on page 20.

Maternity Benefits *continued*

For whom

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

What is not covered

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

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

Mental Conditions/Substance Abuse Benefits

What is covered

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

Inpatient care

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

Outpatient care

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

PPO benefit

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

Non-PPO benefit

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

Benefit limitations

Annual maximum

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

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

Lifetime maximum

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

Precertification-Inpatient care

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

Preauthorization-Outpatient care

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

Mental Conditions/Substance Abuse Benefits *continued*

What is not covered

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

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

Other Medical Benefits

What is covered

Outpatient physician visits

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

PPO benefit

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

Non-PPO benefit

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

Chiropractic treatment

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

Other services

PPO benefit

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

Non-PPO benefit

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

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

- Hospital visits and inpatient consultations.
- Diagnostic services such as X-rays, electrocardiograms, laboratory tests, allergy tests and pre-admission testing.
- Durable medical equipment (as defined on page 35), such as a wheelchair, kidney machine and oxygen, rented or purchased at the Plan's option.*
- Established outpatient cardiac and pulmonary rehabilitation programs.*
- Radiation therapy.
- Chemotherapy for cancer.
- Renal dialysis.
- Necessary supplies and accessories for use in connection with home dialysis, hyperalimentation and intravenous therapy.*
- Artificial limbs, joints and eyes; pacemakers; and leg, arm, neck, and back braces; but not replacement, adjustment, or repair of braces, unless replacement is necessary due to the growth of a child.*
- Stump hose for artificial limbs.
- Internal (implants) and external breast prostheses, and bras for use with external prostheses following mastectomy.
- Internal (implant) ocular lenses and/or the first contact lenses required to correct an impairment caused by trauma or disease. The services of an optometrist are limited to the testing, evaluation and fitting of the first contact lenses required to correct an impairment caused by trauma or disease.
- Catheters, permanent tracheotomy tubes, ostomy bags and supplies and accessories required for attachment.*
- Intra-uterine devices (including the cost of insertion and removal).

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

Other Medical Benefits *continued*

Home health care and rehabilitative therapy

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

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

Outpatient hospital services

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

Medical emergency

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

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

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

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

Preventive services

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

Breast cancer screening

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

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

Cervical cancer screening

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

Colorectal cancer screening

- Annual coverage of one fecal occult blood test for members age 40 and older
- From age 50, one screening sigmoidoscopy every five years

Prostate cancer screening

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

Nonfasting total blood cholesterol test

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

Tetanus diphtheria (Td) booster

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

Other Medical Benefits *continued*

Influenza and Pneumococcal vaccines

Covered once annually per covered person age 65 years and over

Limited benefits

Childhood immunizations

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

Smoking cessation benefit

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

What is not covered

- Routine physical examinations, routine eye examinations, and immunizations.**
- Eyeglasses, contact lenses except as shown above, eye exercises and visual training.**
- Hearing aids and examinations for them.**
- Professional fees for automated lab tests.
- Weight reduction/control and treatment of obesity except as shown on page 12.**
- Orthopedic shoes, foot appliances or any related expenses, elastic stockings, corsets; lumbosacral, neck or joint supports; trusses, air purifiers, whirlpool equipment, sun and heat lamps, light boxes, heating pads, exercise devices, stair glides and elevators.
- Drugs and medicines that can be purchased without a doctor's prescription, even if a doctor has prescribed them or recommended their use.
- Nursing services and rehabilitative therapy without prior Plan approval.
- Speech therapy for developmental delay.
- Services of nurses aides or home health aides.
- Administration of high dose chemotherapy when supported by non-covered autologous bone marrow transplants.
- Maintenance therapies.

**May be eligible for Wellness benefit (see page 20).

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

Additional Benefits

The additional benefits described on this page and on page 20 are not subject to any deductibles.

Accidental injury

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

PPO benefit

100% of provider's negotiated fees.

Non-PPO benefit

100% of reasonable and customary charges.

24-hour nurse advisory

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

Hospice care

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

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

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

Additional Benefits *continued*

Preventive benefits

The Plan pays for the following preventive benefits (see also Preventive services under Other Medical Benefits on pages 18 and 19):

Well child care

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

PPO benefit

100% for children ages birth through 12.

Non-PPO benefit

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

Childhood immunizations

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

PPO benefit

100% of provider's negotiated fees.

Non-PPO benefit

100% of reasonable and customary charges.

Wellness benefit

The Plan reimburses up to **$250** per Self Only enrollment and **$350** per Self and Family enrollment per calendar year for non-covered expenses such as vision care, eyeglasses, hearing aids, if received in 2000 and no other benefits for 2000 have been paid. If the Plan paid claims of less than $350 for a Self and Family enrollment, the difference up to **$**350 will be paid. See page 27 for additional claims information.

Review and reward program

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

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

Prescription Drug Benefits

What is covered

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

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

What is not covered

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

Prescription Drug Benefits *continued*

From a pharmacy

Plan pharmacy

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

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

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

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

Waiver

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

Non-Plan pharmacy

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

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

Waiver

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

To claim benefits

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

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

By mail

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

The Plan pays **100%** after a $7 copayment for covered generic drugs and medicines and a $25 copayment for covered brand name drugs when purchased through the Plan's Mail order drug program.

If you have Medicare Parts A and B as your primary payer, the Plan pays **100%** after a $5 copayment for covered generic drugs and a $15 copayment for brand name drugs when purchased through the Plan’s Mail order drug program.

Charges for Mail order drugs are not subject to any deductible.

Prescription Drug Benefits *continued*

To claim benefits

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

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

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

Purchasing mail order drugs overseas

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

Drugs from other sources

Prescription drugs and antigens for treatment of allergies provided to you by a doctor or facility are covered as Prescription Drugs as shown on page 21.

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

Dental Benefits

What is covered

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

Routine dental care

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

Restorative care

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

ADA code	Amalgam restorations (including polishing)	
2110	Amalgam-one surface	$13
2120	Amalgam-two surfaces	$18
2130	Amalgam-three surfaces	$18
2131	Amalgam-four surfaces	$18
2140	Amalgam-one surface	$13
2150	Amalgam-two surfaces	$18
2160	Amalgam-three surfaces	$18
2161	Amalgam-four surfaces	$18
	Silicate restoration	
2210	Silicate cement per restoration	$13
	Acrylic or plastic or composite resin	
2330	Acrylic or plastic or composite resin-one surface	$13
2331	Acrylic or plastic or composite resin-two surfaces	$18
2332	Acrylic or plastic or composite resin-three surfaces	$18
2335	Acrylic or plastic or composite resin-involving incisal angle or four or more surfaces	$18
	Acrylic or plastic or composite resin	
2380	Resin-one surface, posterior-primary	$13
2381	Resin-two surfaces, posterior-primary	$18
2382	Resin-three or more surfaces, posterior-primary	$18
2385	Resin-one surface, posterior-permanent	$13
2386	Resin-two surfaces, posterior-permanent	$18
2387	Resin-three or more surfaces, posterior-permanent	$18

Dental Benefits *continued*

	Gold foil restorations	
2410	Gold foil-one surface	$13
2420	Gold foil-two surfaces	$18
2430	Gold foil-three surfaces	$18
	Gold inlay restorations	
2510	Gold inlay-one surface	$13
2520	Gold inlay-two surfaces	$18
2530	Gold inlay-three surfaces	$18
	Porcelain restorations	
2610	Porcelain inlay-one surface	$13
2620	Porcelain inlay-two surfaces	$18
2630	Porcelain inlay-three surfaces	$18
2650	Inlay-Composite/Resin-one surface	$13
2651	Inlay-Composite/Resin-two surfaces	$18
2652	Inlay-Composite/Resin-three or more surfaces	$18

Extractions

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

Related benefits

Accidental injury to natural teeth

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

Oral and maxillofacial surgery

For covered oral surgery, see page 14.

What is not covered

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

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, out-of-pocket maximum co-pay charges, etc. These benefits are not subject to the FEHB disputed claims review procedure.

Voluntary Benefits Plan Dental Plan The Voluntary Benefits Plan Dental program is an optional program with an additional premium that supplements the dental benefits in your APWU Health Plan coverage. All participants of the APWU Health Plan who enroll in the Voluntary Benefits Plan Dental Plan through this offer will receive a discount in the regular premiums for that program. To enroll in this additional coverage, complete and sign the Voluntary Benefits Plan Dental Plan enrollment form, which you can obtain from your APWU Health Plan representative or by calling the Voluntary Benefits Plan office at the toll-free number listed below. Please specify that you are an APWU Health Plan participant.

Availability The Voluntary Benefits Plan Dental Plan is available to all Active, Retired, Associate and Transitional Employee APWU Members in all States and Territories of the United States.

Coverage Description This optional dental plan is an indemnity insurance plan underwritten by the Reliance Insurance Company. You may use any dentist you choose. Covered services are reimbursed as a percentage of the "Usual and Customary" charges for that service in the state where the charge is incurred. Once you have satisfied the continuous coverage limitations of the program, there are no further waiting periods as long as you remain continuously insured under the plan. Both you and your eligible dependents (spouse and unmarried children to age 19 - full-time students to age 25) can be insured under this plan.

Coverage Schedule

Calendar Year Deductible: $50 per person - Type I benefits
$100 per person - Type II and Type III benefits, combined

Calendar Year Maximum: $1,000 per person for all covered services
$500 per person for all eligible Orthodontic services, if Optional Orthodontic Coverage is selected

Lifetime Maximum: $1,000 for Orthodontic services, if Optional Orthodontic Coverage is selected

BENEFIT SCHEDULE	After the Annual Deductible, this plan will pay:	
	HIGH OPTION PLAN	LOW OPTION PLAN
TYPE I BENEFITS Preventive Services • Exams • X-rays • Cleanings	100% of the Usual and Customary charges	100% of the Usual and Customary charges
TYPE II BENEFITS Basic Services • Fillings • Oral Surgery • Extractions	80% of the Usual and Customary charges (after 6 months of continuous coverage)	50% of the Usual and Customary charges (after 6 months of continuous coverage)
TYPE III BENEFITS Major Services • Crowns • Bridges • Dentures • Periodontics	50% of the Usual and Customary charges (after 12 months of continuous coverage)	50% of the Usual and Customary charges (after 18 months of continuous coverage)
TYPE IV BENEFITS (Optional Coverage) • Orthodontic	50% of the Usual and Customary charges (after 24 months of continuous coverage)	50% of the Usual and Customary charges (after 24 months of continuous coverage)

This is a partial summary of the terms, conditions and limitations of the Dental Plan policy #NVO-0144842. For more information regarding the coverage, rates or to receive an enrollment form, please contact the Voluntary Benefits Plan office by calling or writing:

Voluntary Benefits Plan
P.O. Box 1471
Waterbury, CT 06721

1-800/442-4492
1-800/237-5536 (In CT)
1-203/754-4410 (T.D.D.)

Benefits on this page are not part of the FEHB contract.

Section 6. How to file a claim

How to Claim Benefits

Claim forms, identification cards and questions

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

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

If you have a question concerning Plan benefits, contact the Carrier at 1-800/222-APWU or you may write to the Carrier at PO Box 3279, Silver Spring, MD 20918. You may also contact the Carrier by fax at 301/622-5712, at its website at http://www.apwuhp.com or by email at custser@apwuhp.com.

How to file claims

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

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

In addition:

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

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

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

APWU Health Plan
Post Office Box 967
Silver Spring, MD 20910
Phone: 1-800/580-8771 (for hospital precertification - see page 33)
Phone: 1-800/222-APWU (benefits verifications)
Phone: 1-301/622-1700 (other business)
FAX: 1-301/622-5712 (not for filing of claims)
TDD line for hearing-impaired: 1-800/622-2511 (TDD equipment required)

How to Claim Benefits *continued*

Wellness Claims

The Plan notifies members in November of each year if they are eligible for the Wellness benefit. Submit Wellness claims after January 1, 2001. Wellness claims are paid after March 1, 2001. If, after Wellness benefits have been paid, subsequent claims are received for hospital, medical or dental expenses, payments made under the Wellness benefit will be deducted from allowable charges.

Records

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

Submit claims promptly

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

Overseas claims

See How to file claims (page 25) and Records (above).

Direct payment to hospital or provider of care

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

When more information is needed

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

Section 7. General exclusions – Things we don't cover

The exclusions in this section apply to all benefits. Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness or condition. The fact that one of our covered providers has prescribed, recommended, or approved a service or supply does not make it medically necessary or eligible for coverage under this Plan.

We do not cover the following:

- Services, drugs or supplies that are not medically necessary;
- Services not required according to accepted standards of medical, dental, or psychiatric practice in the United States;
- Experimental or investigational procedures, treatments, drugs or devices;
- 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;
- Procedures, services, drugs and supplies related to sex transformations, sexual dysfunction or sexual inadequacy except for organic impotence as shown on pages 15 and 20;
- Services or supplies you receive from a provider or facility barred from the FEHB Program;
- Expenses you incurred while you were not enrolled in this Plan;
- Services, drugs and supplies for which no charge would be made if the covered individual had no health insurance coverage;
- Services, drugs and supplies furnished without charge (except as described on page 31); while in active military service; or required for illness or injury sustained on or after the effective date of enrollment (1) as a result of an act of war within the United States, its territories, or possessions or (2) during combat;
- Services, drugs and supplies furnished by immediate relatives or household members, such as spouse, parent, child, brother, or sister by blood, marriage, or adoption;
- Services and supplies furnished or billed by a noncovered facility, except that medically necessary prescription drugs and physical, speech and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to plan limits;
- Services, supplies and drugs not specifically listed as covered;
- Services, supplies and drugs furnished or billed by someone other than a covered provider as defined on page 7;
- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copay or coinsurance, the Carrier will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived;
- Charges the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see pages 31 and 32), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 32), or State premium taxes however applied;
- Biofeedback; nonmedical self care or self help training, such as recreational, educational, or milieu therapy; and
- Charges that the Plan determines to be in excess of the reasonable and customary charge.

Section 8. Limitations – Rules that affect your benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office, or call SSA at 1-800/638-6833.

This Plan and Medicare

Coordinating benefits

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

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

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

This Plan is primary if:

(1) You are age 65 or over, have Medicare Part A (or Parts A and B), and are employed by the Federal Government;
(2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are employed by the Federal Government;
(3) The patient (you or a covered family member) is within the first 30 months of eligibility to receive Medicare Part A benefits due to End Stage Renal Disease (ESRD) except when Medicare (based on age or disability) was the patient's primary payer on the day before he or she became eligible for Medicare Part A due to ESRD; or
(4) The patient (you or a covered family member) is under age 65 and eligible for Medicare solely on the basis of disability, and you are employed by the Federal Government.

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

Medicare is primary if:

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

Medicare is primary if: *(continued)*

(3) You are age 65 or over and (a) you are a Federal judge who retired under title 28, U.S.C., (b) you are a Tax Court judge who retired under Section 7447 of title 26, U.S.C., or (c) you are the covered spouse of a retired judge described in (a) or (b);
(4) You are an annuitant not employed by the Federal Government, and either you or a covered family member (who may or may not be employed by the Federal Government) is under age 65 and eligible for Medicare on the basis of disability;
(5) You are enrolled in Part B only, regardless of your employment status;
(6) You are age 65 or over and employed by the Federal Government in an appointment that excludes similarly appointed nonretired employees from FEHB coverage, and have Medicare Part A (or Parts A and B);
(7) You are a former Federal employee receiving workers' compensation and the Office of Workers Compensation has determined that you are unable to return to duty;
(8) The patient (you or a covered family member) has completed the 30-month ESRD coordination period and is still eligible for Medicare due to ESRD; or
(9) The patient (you or a covered family member) becomes eligible for Medicare due to ESRD after Medicare assumed primary payer status for the patient under rules 1) through 7) above.

When Medicare is Primary

When Medicare is primary, all or part of your Plan deductibles and coinsurance will be waived for services and supplies covered by this Plan as follows:

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

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

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

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

Prescription Drugs: If you are enrolled in Medicare Parts A and B where Medicare is the primary payer, the Plan will waive the coinsurance and deductible applicable to generic prescription drugs (but will waive only the deductible for brand name drugs) obtained from a Plan pharmacy for up to a 30-day supply plus one 30-day refill for each prescription. For subsequent refills from a Plan pharmacy, or for all purchases from a Non-Plan pharmacy, only the deductible is waived; 40% coinsurance applies.

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

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

When you also enroll in a Medicare prepaid plan

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

Medicare's payment and this Plan

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

Medicare's payment and this Plan *(continued)*

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

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

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

How to claim benefits

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

Other group insurance coverage

When anyone has coverage with us and with another group health plan it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

If we pay second, we will determine how much of the charge we will pay for. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge.

Remember: Even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

Automobile insurance

Double coverage also applies when you are entitled to the payment of medical and hospital costs under automobile insurance, including no-fault, that pays without regard to fault. In such case, your automobile insurance will pay first and we will pay second. We will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge.

When others are responsible for injuries

Liability insurance and third party actions

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

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

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

TRICARE

TRICARE is the health care program for members, eligible dependents, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we are the primary payer. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' compensation

We do not cover services that:

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

Once the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

We do not cover services and supplies that a local, State, or Federal Government agency directly or indirectly pays for.

Overpayments

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

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

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

Inpatient hospital care

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

Inpatient hospital care *(continued)*

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

Physician services

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

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

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

If your physician is not a Plan PPO doctor that participates with Medicare, the Plan will base its regular benefit payment on the Medicare-approved amount. For instance, under this Plan's surgery benefit, the Plan will pay 70% of the Medicare-approved amount. You will only be responsible for any deductible and coinsurance equal to 30% of the Medicare-approved amount.

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

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

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

Section 9. Fee-for-Service facts

Precertification

Precertify before admission

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

To precertify a scheduled admission:

- You, your representative, your doctor, or your hospital must call Spectera/CARE Programs at least 48 hours prior to admission. The toll-free number is 1-800/580-8771 and may be reached 24 hours every day. In Minnesota, call PreferredOne at 1-800/451-9597 to precertify. To precertify an admission for mental conditions/substance abuse, see page 16.
- Provide the following information: enrollee's name and Plan identification number; patient's name, birth date and phone number; reason for hospitalization, proposed treatment or surgery; name of hospital or facility; name and phone number of admitting doctor.

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

Need additional days?

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

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

You don't need to certify an admission when:

- Medicare Part A, or another group health insurance policy, is the primary payer for the hospital confinement (see pages 28 and 29). Precertification is required, however, for members with Medicare Part A prior to the 60th day of a Medicare benefit period, when Medicare hospital benefits are exhausted prior to using lifetime reserve days or if being admitted to a Department of Veterans Affairs or Department of Defense hospital.
- You are confined in a hospital outside the United States and Puerto Rico.

Maternity or emergency admissions

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

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

Other considerations

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

If you do not precertify

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

If you do not precertify *(continued)*

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

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

Protection Against Catastrophic Costs

Catastrophic protection

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

Preferred Providers

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

Out-of-pocket expenses

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

- The 10% you pay for PPO Inpatient hospital charges, Surgical, Maternity and Other Medical Benefits;
- The 30% you pay for non-PPO Inpatient hospital charges, Surgical, Maternity and Other Medical Benefits; and
- The copayment of $15 for outpatient visits to PPO physicians (see page 17).

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

- Expenses in excess of reasonable and customary charges or maximum benefit limitations;
- Expenses for mental conditions, substance abuse or dental care;
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see pages 4, 6, 33 and 34);
- Covered expenses applied to the $250 calendar year deductible;
- The $200 per admission deductible for non-PPO Inpatient hospital charges;
- Expenses for prescription drugs;
- Expenses incurred in excess of the $90 per day provided under home nursing care (see page 18); and
- Expenses in excess of hospice care and preventive care maximums.

Carryover

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

Definitions

Accidental injury

An injury resulting from a violent external force.

Admission

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

Assignment

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

Calendar year

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

Congenital anomaly

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

Cosmetic surgery

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

Custodial care

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

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

The Carrier determines which services are custodial care.

Durable medical equipment

Equipment and supplies that:

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

Effective date

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

Experimental or investigational

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

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

Experimental or investigational *(continued)*

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

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

Group health coverage

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

Home health care agency

An agency which meets all of the following:

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

Hospice care program

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

Maintenance therapy

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

Medically necessary

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

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

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

Mental conditions/ Substance abuse

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

Precertification

Precertification is a preliminary determination that the services in question are appropriately performed on an inpatient basis. It does not constitute medical advice (see pages 33 and 34).

Reasonable and customary

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

Reasonable and customary *(continued)*

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

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

Rehabilitative care

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

Section 10. FEHB facts

You have a right to the following information.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website (www.opm.gov) lists the specific types of information that we must make available to you.

If you want specific information about us, call 1-800/222-APWU, or write to APWU Health Plan, P.O. Box 3279, Silver Spring, Maryland 20918. You may also contact us by fax at 301/622-5712, or visit our website at www.apwuhp.com.

Where do I get information about enrolling in the FEHB Program?

Your employing or retirement office can answer your questions, and give you a "Guide to Federal Employees Health Benefits Plans," brochures for other plans and other materials you need to make an informed decision about:

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

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

When are my benefits and premiums effective?

The benefits in this brochure are effective on January 1. If you are new to this plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin January 1.

What happens when I retire?

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

What types of coverage are available for me and my family?

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

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth or add a child to your family. You may change your enrollment 31 days before to 60 days after you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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

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

Are my medical and claims records confidential?

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

- OPM, this Plan, and our subcontractors when they administer this contract,
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims,
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions,
- OPM and the General Accounting Office when conducting audits,
- Individuals involved in bona fide medical research or education that does not disclose your identity, or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

What if I paid a deductible under my old plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

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

When you lose benefits

What happens if my enrollment in this Plan ends?

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

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

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

What is former spouse coverage?

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get more information about your coverage choices.

What is TCC?

Temporary Continuation of Coverage (TCC). If you leave Federal service or if you lose coverage because you no longer qualify as a family member, you may be eligible for TCC. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire. You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Get the RI 79-27, which describes TCC, and the RI 70-5, "The Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees" from your employing or retirement office.

Key points about TCC:

- You can pick a new plan,
- If you leave Federal service, you can receive TCC for up to 18 months after you separate,
- If you no longer qualify as a family member, you can receive TCC for up to 36 months,
- Your TCC enrollment starts after regular coverage ends,
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed,
- You pay the total premium, and generally a 2 percent administrative charge. The government does not share your costs,
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium,
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

How can I convert to individual coverage?

You may convert to an individual policy if:

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

If you leave Federal service, your employing office will notify you if individual coverage is available. You must apply in writing to us within 31 days after you receive this notice.

However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

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

How can I get a Certificate of Group Health Plan Coverage?

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. You must arrange for the other coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on the information in the certificate.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may request a certificate from them, as well.

Department of Defense/FEHB Demonstration Project

What is the Department of Defense (DoD) and FEHB Demonstration Project?

The National Defense Authorization Act of 1999, Public Law 105-261, established the DoD/FEHBP Demonstration Project. It allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years beginning with the 1999 Open Season for the year 2000. Open Season enrollments will be effective January 1, 2000. DoD and OPM have set up some special procedures to successfully implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is eligible?

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

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

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

Where are the demonstration areas?

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

When can I join?

Your first opportunity to enroll will be during the 1999 Open Season, November 8, 1999, through December 13, 1999. Your coverage will begin January 1, 2000. DoD has set up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877-DOD-FEHB (1-877-363-3342).

You may select coverage for yourself (Self Only) or for you and your family (Self and Family) during the 1999, 2000, 2001 Open Seasons. Your coverage will begin January 1 of the year following the Open Season that you enrolled.

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

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including "The 2000 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHBP Demonstration Project," on the OPM web site at www.opm.gov.

Am I eligible for Temporary Continuation of Coverage (TCC)?

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

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

Do I have the 31-Day Extension and Right to Convert?

These provisions do not apply to the DoD/FEHBP Demonstration Project.

Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us 1-800/222-APWU and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, D.C. 20415

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

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Surgery (transplant), 13
Surgical benefits, 12, 13, 14
Syringes, 20
Transplants, 13, 14, 23
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Wellness benefit, 14, 19, 26
Wheelchair, 17
Workers' compensation, 29, 31
X-rays, 6, 9, 11, 14, 15, 17, 18, 22, 23, 24, 36

Summary of benefits for the APWU Health Plan -- 2000

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

	Benefits	Plan pays/provides	Page
Inpatient care	**Hospital**	**PPO benefit: 90%** of room and board and other charges, no deductible **Non-PPO benefit:** After a $200 deductible per admission, **70%** of room and board and other charge	11-12
	Surgical	**PPO benefit: 90%*** of the physician's negotiated fee **Non-PPO benefit: 70%*** of reasonable and customary charges	12-14
	Medical	Same as Surgical Inpatient Benefit	17-19
	Maternity	Same benefits as for illness or injury	14-16
	Mental Conditions	**PPO benefit:** After a $250 annual deductible, **60%** up to 45 days per year **Non-PPO benefit:** After a $750 annual deductible, **50%** up to 30 days per year	16-17
	Substance Abuse	Same as Mental Conditions limited to one treatment program per member per lifetime up to a maximum Plan payment of $3,000	16
Outpatient care	**Hospital**	**PPO benefit: 90%*** of covered hospital charges **Non-PPO benefit: 70%*** of reasonable and customary charges	18
	Surgical	**PPO benefit: 90%*** of the physician's negotiated fee **Non-PPO benefit: 70%*** of reasonable and customary charges	12-14
	Medical	**PPO benefit:** $15 copay per covered visit; **90%*** of physician's negotiated fee for other covered services **Non-PPO benefit: 70%*** of reasonable and customary charges	17-19
	Maternity	Same benefits as for illness or injury	14-16
	Home Health Care	**70%*** of reasonable and customary charges	18
	Mental Conditions/ Substance Abuse	**PPO benefit:** After a $250 annual deductible, **70%** of provider's negotiated fees up to 30 visits per year **Non-PPO benefit:** After a $750 annual deductible, **50%** of reasonable and customary charges up to 15 visits per year	16-17
Emergency care (accidental injury)		**PPO benefit: 100%** of providers' negotiated fees (no deductible) within 24 hours **Non-PPO benefit: 100%** of reasonable and customary charges (no deductible) within 24 hours	19
Prescription drug benefits		Pharmacy: **80%** of drug charges purchased from a Plan pharmacy (**60%** from a non-Plan pharmacy) after $50 per person/ $100 per family prescription drug deductible	20-22
		Mail order: (non-Medicare) **$7 copay** for generic drugs, **$25 copay** for brand name drugs (no deductible)	21-22
		(Medicare) **$5 copay** for generic drugs, **$15 copay** for brand name drugs (no deductible)	21-22
Dental care		Actual charges up to amounts shown for listed procedures	22-23
Additional benefits		Hospice Care, Childhood Immunizations, Well Child, Wellness, Review and Reward Program, 24-hour nurse advisory service	19-20
Protection against catastrophic costs		**100%** of covered charges when applicable coinsurance in a calendar year exceeds $2,000 per Self Only or Self and Family enrollment when PPO providers are used and $3,500 per Self Only or Self and Family enrollment when they are not	34

2000 Rate Information for American Postal Workers Union Health Plan

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

Postal rates apply to most career U.S. Postal Service employees. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee, but not a member of a special postal employment class, refer to the category definitions in "The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees," RI 70-2, to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans."

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
Self Only	**471**	**$78.83**	**$39.72**	**$170.80**	**$86.06**	**$93.06**	**$25.49**	**$93.26**	**$25.29**
Self and Family	**472**	**$175.97**	**$84.20**	**$381.27**	**$182.43**	**$207.74**	**$52.43**	**$201.02**	**$59.15**