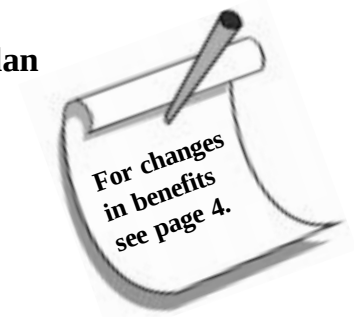
American Foreign Service Protective Association

Foreign Service Benefit Plan 2000

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



Sponsored by the American Foreign Service Protective Association

Who may enroll in this Plan: You must be, or become, a member of the American Foreign Service Protective Association.

To become a member: When you enroll in the Foreign Service Benefit Plan, you automatically become a member of the Protective Association. New membership in the Protective Association is limited to American Foreign Service personnel and GS direct hire employees working for (1) the Department of State (2) the Agency for International Development (3) the Foreign Commercial Service (4) the Foreign Agricultural Service; and to Executive Branch civilian employees, including Department of Defense civilians, assigned overseas on a regular tour of duty.

GS direct hire employees and Executive Branch civilian employees must enroll in the Health Plan when actively employed in order to retain or choose the Plan in retirement. Only annuitants who are eligible under the Foreign Service Retirement System may enroll under this Plan as annuitants.

Membership dues: There are no membership dues. Membership is for life.

Enrollment code for this Plan:
401 Self only
402 Self and family

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

Authorized for distribution by the:

United States Office of Personnel Management

FEHB Federal Employees Health Benefits Program

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Table of Contents

Introduction

Foreign Service Benefit Plan
1716 N Street, NW
Washington, DC 20036-2902

This brochure describes the benefits you can receive from the Foreign Service Benefit Plan under its contract CS 1062 with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This Plan is underwritten by the Mutual of Omaha Insurance Company.

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 4. 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 the Foreign Service Benefit 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 plans (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 preauthorization.** 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 preauthorization.
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

- To keep your premium as low as possible, OPM has set a maximum PPO benefit of **90%** and a maximum non-PPO benefit of **85%** for Medical, Surgical, Anesthesia and Delivery professional services.
- 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 the physician's office does 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

- The Plan has expanded the PPO Network Area to include certain areas in the following States: California, Florida, New York, Texas and Washington.
- The Plan has increased benefits for Inpatient Hospital Other Charges from **85%** to **90%** of reasonable and customary charges for PPO and Outside of PPO Network Area benefits.
- The Plan has increased benefits for Inpatient Hospital Other Charges for Mental Conditions from **85%** to **90%** of reasonable and customary charges for PPO and Outside of PPO Network Area benefits.
- The Plan has increased the maximum dollar payment for Mental Conditions inpatient doctor visits from $40 to $60 under both the PPO and non-PPO benefit.
- The Plan has increased the maximum dollar payment for Mental Conditions inpatient group therapy from $15 to $30 per session under both the PPO and non-PPO benefit.
- The Plan has increased the maximum dollar payment for Mental Conditions outpatient group therapy from $25 to $40 per session under both the PPO and non-PPO benefit.
- The Plan has increased the maximum charge allowable in Other Medical Benefits under the routine physical examination benefit from $250 to $500 per person per calendar year. In addition, the Plan has removed the cervical cancer screening benefit from the routine physical exam benefit and now provides a separate benefit under routine services.
- The Plan has changed its Prescription Drug Benefits as follows: added a Drug Card; changed the copayments of the Mail Order Drug Program; changed the coinsurance on drugs purchased from a non-participating pharmacy; and changed the Medicare waiver of coinsurance and copayments. See pages 23-24 for complete details.
- Your share of the premium will increase by 9.4% for Self Only or 8.8% for Self and Family.

Section 3. How to get benefits

How do I keep my health care expenses down?

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 PPOs, to help contain costs. In addition, this Plan requires precertification of home health care, hospice and skilled nursing facility admissions.

You can help

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. Precertification is also required for home health care, hospice and skilled nursing facility admissions under this Plan. You are responsible for ensuring that the precertification requirement is met. You or your doctor must check with this Plan before being admitted to the hospital. If that doesn't happen, this Plan will reduce benefits by $500. In addition, you or your doctor must check with this Plan before being admitted to a hospice or skilled nursing facility, or receiving home health care. If that doesn't happen, this Plan will pay reduced benefits. 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 pages 35 and 36 of this brochure.

Flexible benefits option

Under the flexible benefits option, the Plan has the authority to determine the most effective way to provide services. The Plan 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 Plan 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 Plan's and may be withdrawn at any time. It is not subject to OPM review under the disputed claims process.

PPO

This Plan offers its members in the Washington, D.C. metropolitan and Greater Baltimore area and certain areas of the States of California, Florida, New York, Texas and Washington the opportunity to reduce out-of-pocket expenses by choosing facilities and providers who participate in the Plan's Preferred Provider Organization (PPO). Consider the PPO cost savings when you review Plan benefits and if you live in these areas check with the Plan to find out which local facilities and providers are PPO providers. Check with your doctor to see whether he or she has admitting privileges at a PPO hospital.

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 a deductible. When a benefit is subject to a deductible, only expenses allowable under that benefit count toward the deductible.

Calendar year

The calendar year deductible is the amount of expenses an individual must incur for covered services and supplies each calendar year before the Plan pays Other Medical Benefits and outpatient treatment of mental conditions. The deductible is $250 per person and $500 per family. Expenses are "incurred" on the date on which the service or supply is received.

Hospital

There is a separate deductible of $175 per person per confinement for inpatient hospital room and board expenses for non-PPO confinements in the Plan's PPO Network Area and for all confinements elsewhere. Each family member must satisfy this deductible.

Section 3. How to get benefits *continued*

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 for each person. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the deductible for all family members reach $500 during a calendar year.

The calendar year deductible is applied only once in a calendar year regardless of how many different illnesses or accidents a person may have. Furthermore, if two or more covered members of your family are injured in the same accident, you have to pay only one deductible for those members injured in the accident.

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 the Plan pays 80% of reasonable and customary charges for a covered service, you are responsible for 20% of the reasonable and customary charges, i.e., the coinsurance. In addition, you are responsible for any excess charge over the Plan's reasonable and customary allowance. For example, if the provider ordinarily charges $100 for a service but the Plan's reasonable and customary allowance is $95, the Plan will pay 80% of the allowance ($76). You must pay the 20% coinsurance ($19), plus the difference between the actual charge and the reasonable and customary allowance ($5), for a total member responsibility of $24. Remember, if you use preferred providers, your share of covered charges (after meeting the deductible) is limited to the stated coinsurance amount.

Copayments

A copayment is the stated amount the Plan may require you to pay for a covered service, such as $10.00 for generic or $20.00 for brand name prescriptions purchased from a participating pharmacy and $15.00 for generic and $25.00 for brand name prescriptions purchased through the Mail Order Drug Program.

If provider waives your share

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

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 34), the Plan will pay 30% of the total covered amount as room and board charges and 70% as other charges and will apply your coinsurance accordingly.

Lifetime maximums

- The Hospice benefit is limited to $7,500 per person per lifetime when the hospice care is precertified.
- The Hospice benefit is limited to $4,500 per person per lifetime when the hospice care is not precertified.
- The Orthodontic benefit is limited to $1,000 per person per lifetime.
- The Substance abuse benefit is limited to two treatment programs per person per lifetime.
- The Smoking cessation benefit is limited to one per person per lifetime.
- Diagnosis and treatment of infertility is limited to a maximum benefit of $5,000 per person per lifetime.

Section 3. How to get benefits *continued*

Do I have to submit claims?

You do not have to submit claims to us if you use preferred providers. When you file a claim (for non-PPO Providers and overseas providers, for example), please send us all of the documents for your claim as soon as possible. You should submit claims within 90 days after the expense for which the claim being made was incurred but in no event later than 2 years from the date the expense in question was incurred. We can extend this deadline if timely filing was prevented by administrative operations of Government or legal incapacity, provided you submit the claim as soon as reasonably possible.

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

Birthing center

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

Day care center

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

Hospice

A public or private agency or organization that:

1) primarily provides inpatient hospice care to terminally ill persons;
2) is certified by Medicare as such, or is licensed or accredited as such by the jurisdiction it is in;
3) is supervised by a staff of M.D.'s or D.O.'s at least one of whom must be on call at all times;
4) provides 24-hour-a-day nursing services under the direction of an R.N. and has a fulltime administrator; and
5) provides an ongoing quality assurance program.

Hospital

1) An institution that is accredited as a hospital under the hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or
2) Any other institution that is operated pursuant to law, under the supervision of a staff of doctors and with 24-hour-a-day nursing services, and that 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 facilities must be provided on its premises or under its control; or
   b) Specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital (as defined above) or with a specialized provider of those facilities.
3) For inpatient and outpatient treatment of alcohol and drug abuse, the term hospital also includes a free-standing alcohol and drug abuse treatment facility approved by the JCAHO.

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

1) is used principally as a convalescent facility, rest facility, nursing facility or facility for the aged;
2) furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or
3) is operated as a school.

Section 3. How to get benefits *continued*

Skilled nursing facility

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

Covered providers

Covered providers include:

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

Other covered providers include:

- **Qualified Clinical Psychologist** — An individual who has earned either a Doctoral or Masters degree in psychology or an allied discipline and who is licensed or certified in the state where services are performed (such as Licensed Professional Counselors).
- **Nurse Midwife** — A person who is certified by the American College of Nurse Midwives or is licensed or certified as a nurse midwife in states requiring licensure or certification.
- **Nurse Practitioner / Clinical Specialist** — A person who 1) has an active R.N. license in the United States, 2) has a baccalaureate or higher degree in nursing, and 3) is licensed or certified as a nurse practitioner or clinical nurse specialist in states requiring licensure or certification.
- **Clinical Social Worker** — A social worker who 1) has a Masters or Doctoral degree in social work, 2) has at least two years of clinical social work practice, and 3) in states requiring licensure, certification, or registration, is licensed, certified, or registered as a social worker where the services are rendered.
- **Nursing School Administered Clinic** — A clinic that is 1) licensed or certified in the state where the services are performed, and 2) provides ambulatory care in an outpatient setting — primarily in rural or inner city areas where there is a shortage of physicians. Services billed for by these clinics are considered outpatient "office" services rather than facility charges.
- **Physician Assistant** — A person who is licensed, registered or certified in the state where services are performed.
- **Audiologist** — A person who is licensed, registered or certified in the state where services are performed.

For purposes of this FEHB brochure, the term "doctor" includes all of these providers when the services are performed within the scope of their license or certification.

Coverage in medically underserved areas

Within States designated as medically underserved areas, any licensed medical practitioner will be treated as a covered provider for any covered services performed within the scope of that 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

PPO facilities and providers agree to provide service to Plan members at a lesser cost than for the same service from a non-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 provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply. **You must present your PPO Identification Card confirming your PPO participation to be eligible for PPO benefits.**

This Plan's PPO

The Plan has entered into an arrangement with Mutual of Omaha's Preferred Provider Organization (PPO). This is a group of doctors and hospitals in certain areas that have contracted with Mutual to provide medical services at reduced costs. Each time you need medical care by a doctor or hospital you have the choice to use a health care provider who participates in the network or one who doesn't. Regardless of the provider you choose, benefits will be subject to all terms, conditions and limitations of the Plan. In addition, the Plan does not supervise, control or guarantee the health care services of any preferred provider or other provider. When you phone for an appointment, please verify that the physician is still a PPO provider. **When you visit the provider present your PPO Identification Card confirming your PPO participation.**

Section 3. How to get benefits *continued*

When you use a PPO provider

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

(1) a part of a health care facility; or

(2) the furnishing of certain covered services.

The selection of PPO providers is solely the Plan's responsibility; continued participation of any specific provider cannot be guaranteed.

Enrollees living in the PPO Network Area, as defined on the following page, may use the PPO network when they get local doctor and/or hospital care. Subject to the Plan's definitions, limitations and exclusions, the Plan pays **100%** of covered charges for a semi-private room and **90%** of other covered hospital charges with no deductible for members who are admitted to a PPO provider facility, **90%** of covered charges for a doctor for surgical services and **90%** of covered charges in excess of the deductible for services of a doctor other than for surgery until the member's out-of-pocket expense equals the catastrophic limit. The Plan will then pay **100%** of these charges. If you live in the PPO Network Area listed on this page, access the PPO directory either through Mutual of Omaha's web site http://www.mutualofomaha.com or as a link through our web site at http://www.afspa.org or call 202/833-4910 for information concerning the PPO.

When you use a non-PPO provider in this area

Enrollees living in the PPO Network Area who elect to be admitted to a non-PPO facility will be required to pay a $175 per confinement per person deductible. The Plan will then pay **80%** of covered charges for a semi-private room and board rate and **85**% for other covered hospital charges until the member's out-of-pocket expense equals the catastrophic limit. The Plan will then pay these charges at **100%**.

If you elect to use the services of a non-PPO doctor, the Plan will pay **80**% of covered charges of a doctor for surgical services and **80%** for covered charges in excess of the deductible for services of a doctor other than for surgery until the member's out-of-pocket expense equals the catastrophic limit. The Plan will then pay **100%** of these charges.

Outside the Network Area

Enrollees living outside the PPO Network Area will be required to pay a $175 per admission per person deductible if confined in a hospital. The Plan will then pay **100%** of covered charges for a semi-private room and board rate and **90%** of other covered hospital charges until the member's out-of-pocket expense equals the catastrophic limit. The Plan will then pay **100%** of these charges.

The Plan will pay **90%** of covered charges of a doctor for surgical services and **80%** for covered charges in excess of the deductible for services of a doctor other than for surgery until the member's out-of-pocket expense equals the catastrophic limit. The Plan will then pay **100%** of these charges.

PPO Network Area

The PPO Network Area for 2000 consists of Washington, D. C. and certain counties in the following States:

California	Florida	Maryland	New York
Texas	Virginia	Washington	

If you live in the counties of these States that are included in the Plan's PPO area, the Plan will send you a PPO Identification Card and a PPO Directory. You may obtain information on the Plan's PPO providers by visiting Mutual of Omaha's web site at http://www.mutualofomaha.com, or as a link through our web site at http://www.afspa.org or calling us at 202/833-4910 for information concerning the PPO.

Section 3. How to get benefits *continued*

If you live in these areas and receive services or supplies from any non-PPO facility or provider in any of these localities, it could result in higher out-of-pocket costs to you. You must use PPO Providers to receive maximum Plan benefits when you obtain care in the PPO Network Area.

Outside the Network Area

Enrollees living outside the PPO Network Area will be reimbursed by this Plan at regular Plan benefits.

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

First, call our customer service department at 202/833-4910. 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?

The procedures the Plan follows in determining whether a drug, device or biological product is experimental or investigational are explained in the definition below.

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.

If you need additional information regarding the determination of experimental and investigational, please contact the Plan.

Section 4. What if we deny your claim or request for preauthorization

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 include copies of an operative or procedure report, or other documentation that supports your claim.

If we deny your request for preauthorization 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 preauthorization; or
4. Ask for more information

If we ask your medical provider for more information, we will send you a letter advising you of this 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 preauthorization.

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

Call us at 202/833-4910 and we will expedite our review.

What if you have denied my request for preauthorization 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 claim 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 the 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.

Section 4. What if we deny your claim or request for preauthorization *continued*

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 two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See pages 35 and 36 for details.

Waiver

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

Room and board

Semiprivate, ward and intensive care accommodations, including general nursing care, meals, and special diets, are covered. If a private room is used, only the hospital's average semiprivate room rate will be considered a covered expense. However, if the patient's isolation is required to prevent contagion to others, the charge for a private room will be covered.

PPO Benefits

(If you live in the PPO Network Area)

The Plan pays **100%** of semiprivate room and board charges.

Non-PPO Benefits

(If you live in the PPO Network Area)

After a $175 inpatient hospital deductible per person per confinement is satisfied, the Plan pays **80%** of semiprivate room and board charges.

Outside the PPO Network Area

After the $175 inpatient hospital deductible per person per confinement, the Plan pays **100%** of semiprivate room and board charges.

Other charges

The Plan pays the applicable percent shown below of reasonable and customary charges for all covered hospital charges other than room and board, including services and supplies received while in a hospital. These include but are not limited to:

- Use of operating room;
- Surgical dressings;
- Drugs and medications for use in the hospital;
- X-ray and laboratory examinations;
- Blood or blood plasma, if not donated or replaced, and its administration; and
- Inpatient private duty nursing services by an R.N. or L.P.N. when the services are rendered outside of North America.

PPO Benefits

(If you live in the PPO Network Area)

The Plan pays **90%** of reasonable and customary charges.

Non-PPO Benefits

(If you live in the PPO Network Area)

The Plan pays **85%** of reasonable and customary charges.

Outside the PPO Network Area

The Plan pays **90%** of reasonable and customary charges.

Section 5. Benefits *continued*

Limited benefits

Pre-admission testing — The Plan pays **100%** of reasonable and customary charges for preadmission tests received within 72 hours before admission to a hospital.

Hospitalization for dental work — Hospital charges are covered when a nondental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient, even though no benefits may be payable for services of dentists or doctors in connection with the dental treatment. See page 25 for dental services covered by the Plan.

Related benefits

Mental conditions — Charges for hospital expenses for treatment of mental conditions are not covered under Inpatient Hospital Benefits. Coverage for treatment of mental conditions is discussed on pages 18 and 19.

Professional charges — Charges for professional services of a doctor or any other practitioner covered under this Plan, even though billed by a hospital as part of hospital services, are covered only under Surgical Benefits, Maternity Benefits, Mental Conditions/Substance Abuse Benefits, Other Medical Benefits or Additional Benefits (pages 14-22).

Skilled nursing facility — Benefits provided are covered under Additional Benefits; see page 23.

Prosthetic appliances — Prosthetic appliances (e.g., pacemakers, artificial hips, intraocular lenses) are covered only under Other Medical Benefits (page 20).

Take-home items — Drugs, medical supplies, medical equipment and any covered items billed by a hospital but to be used at home are covered under Other Medical Benefits (page 20).

What is not covered

- Confinement in nursing homes, rest homes, places for the aged, convalescent homes or any place that is not a hospital, skilled nursing care facility or hospice (see Facilities and Other Providers on pages 7 and 8)
- Custodial care (as defined on page 38) even when provided by a hospital
- A hospital admission that is not medically necessary, i.e., the medical services did not require the acute hospital inpatient (overnight) setting, but could have been provided in a doctor's office, the outpatient department of a hospital, or some other setting without adversely affecting the patient's condition or the quality of medical care rendered
- Inpatient private duty nursing except as provided on the previous page
- Personal comfort items such as radio, television, telephone, beauty and barber services, ID tags, baby beads, footprints, guest cots, guest meals, newspapers and similar items

The standard benefits of this Plan apply for the out-of-network area. PPO benefits are available only in the PPO Network Area and apply only when you use a PPO Provider. If you live in the PPO area and do not use a PPO provider, non-PPO benefits apply.

Surgical Benefits

What is covered — The Plan pays for the following services:

Hospital inpatient

PPO Benefit — (If you live in the PPO Network Area)

The Plan pays **90%** of reasonable and customary charges for surgery.

Non-PPO Benefit — (If you live in the PPO Network Area)

The Plan pays **80%** of reasonable and customary charges for surgery.

Outside the PPO Network Area Benefit — The Plan pays **90%** of reasonable and customary charges for surgery.

Section 5. Benefits *continued*

Outpatient

PPO Benefit

(If you live in the PPO Network Area)

The Plan pays **90%** of reasonable and customary charges for surgery. The Plan also pays **90%** reasonable and customary charges by a hospital, physician, or approved surgicenter for outpatient services and supplies furnished within 72 hours of an outpatient surgical operation. Laboratory tests, tissue pathology, and supplies in relation to office surgery are also covered under this benefit (except as shown on page 16).

Non-PPO Benefit

(If you live in the PPO Network Area)

The Plan pays **80%** of reasonable and customary charges for surgery. The Plan also pays **80%** reasonable and customary charges by a hospital, physician, or approved surgicenter for outpatient services and supplies furnished within 72 hours of an outpatient surgical operation. Laboratory tests, tissue pathology, and supplies in relation to office surgery are also covered under this benefit (except as shown on page 16).

Outside the PPO Network Area Benefit

The Plan pays **90%** of reasonable and customary charges for surgery. The Plan also pays **90%** reasonable and customary charges by a hospital, physician, or approved surgicenter for outpatient services and supplies furnished within 72 hours of an outpatient surgical operation. Laboratory tests, tissue pathology, and supplies in relation to office surgery are also covered under this benefit (except as shown on page 16).

Multiple surgical procedures

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

Incidental procedures

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

Assistant surgeon (inpatient/outpatient)

Charges by an assistant surgeon in connection with inpatient or outpatient surgery are covered at **80%** of reasonable and customary charges (based on **20%** of the reasonable and customary charge allocated to the surgeon) when determined by the Plan to be medically necessary.

Anesthesia

PPO Benefit

(If you live in the PPO Network Area)

The Plan pays **90%** of reasonable and customary charges for general administration of anesthesia in or out of a hospital.

Non-PPO Benefit

(If you live in the PPO Network Area)

The Plan pays **80%** of reasonable and customary charges for general administration of anesthesia in or out of a hospital.

Outside the PPO Network Area

The Plan pays **90%** of reasonable and customary charges for general administration of anesthesia in or out of a hospital.

Organ/tissue transplants and donor expenses

All reasonable and customary charges incurred for a covered surgical transplant, whether incurred by the recipient or donor, will be considered expenses of the recipient and will be covered the same as for any other illness or injury. This benefit applies only if the recipient is covered by the Plan.

Transplant surgery means transfer of a body organ(s) from the donor to the recipient.

Recipient means an insured person who undergoes a surgical operation to receive a body organ(s) transplant.

Donor means a person who undergoes a surgical operation for the purpose of donating a body organ(s) for transplant surgery.

Section 5. Benefits *continued*

What is covered

- Cornea, heart, kidney, liver, pancreas, heart/lung, single lung and double lung transplants
- Bone marrow and stem cell support as follows:

  Allogeneic bone marrow transplants

  Autologous bone marrow transplants (autologous stem cell support) and autologous peripheral stem cell support for 1) acute lymphocytic or non-lymphocytic leukemia; 2) advanced Hodgkin's lymphoma; 3) advanced non-Hodgkin's lymphoma; 4) advanced neuroblastoma; 5) testicular, mediastinal, retroperitoneal and ovarian germ cell tumors; 6) breast cancer; 7) multiple myeloma; and 8) epithelial ovarian cancer
- 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; services or supplies for, or related to, surgical transplant procedures for artificial or human organ transplants not listed as covered.

Oral and maxillofacial surgery

Charges of an oral surgeon (D.D.S. or D.M.D.) for removal of impacted teeth or for a nondental surgical operation performed on the jaw or in the mouth will be covered as shown on pages 14 and 15. Oral surgery that involves any tooth or tooth structure, alveolar process, abscess, periodontal disease or disease of gingival tissue is not covered by the Plan except as provided under Dental Benefits (see page 25).

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.

Benefits will be provided for 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. (Breast prostheses are covered under Other Medical Benefits. See page 20).

Related benefits

Prosthetic appliances

Prosthetic appliances (e.g., pacemakers, artificial hips, intraocular lenses) are covered only under Other Medical Benefits (page 20).

Second opinion (voluntary)

Charges of an independent consulting doctor are covered under Other Medical Benefits (see page 20).

Take-home items

Drugs, medical supplies, medical equipment and any covered items billed by a hospital, physician or approved surgicenter but to be used at home are covered under Other Medical Benefits (page 20).

What is not covered

- Cosmetic surgery (as defined on page 38), except for the repair of accidental injuries sustained while covered under the FEHB Program; to correct a congenital anomaly; or for the reconstruction of a breast following a mastectomy
- Radial keratotomy
- Treatment or removal of corns and calluses, or trimming of toenails

The standard benefits of this Plan apply for the out-of-network area. PPO benefits are available only in the PPO Network Area and apply only when you use a PPO Provider. If you live in the PPO area and do not use a PPO provider, non-PPO benefits apply.

Section 5. Benefits *continued*

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 cesarean delivery. Inpatient stays will be extended if medically necessary.

Inpatient hospital

Precertification

The medical necessity of your hospital admission must be precertified for you to receive full Plan benefits. Unscheduled or emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Newborn confinements that extend beyond the mother's discharge must also be precertified. If any of the above are not done, the benefits payable will be reduced by $500. See pages 35 and 36 for details.

Waiver

See page 35 for exceptions to the precertification requirement.

Room and Board

PPO Benefits

(If you live in the PPO Network Area)

The Plan pays **100%** of semiprivate room and board charges.

Non-PPO Benefits

(If you live in the PPO Network Area)

After a $175 inpatient hospital deductible per person per confinement, the Plan pays **80%** of semiprivate room and board charges.

Outside the PPO Network Area

After the $175 inpatient hospital deductible per person per confinement, the Plan pays **100%** of semiprivate room and board charges.

Other Charges

PPO Benefits

(If you live in the PPO Network Area)

The Plan pays **90%** of reasonable and customary charges for all other covered hospital charges, including anesthesia supplies and ambulance.

Non-PPO Benefits

(If you live in the PPO Network Area)

The Plan pays **85%** of reasonable and customary charges for all other covered hospital charges, including anesthesia supplies and ambulance.

Outside the PPO Network Area

The Plan pays **90%** of reasonable and customary charges for all other covered hospital charges, including anesthesia supplies and ambulance.

Obstetrical care

Bassinet or nursery charges for days on which mother and child are both confined are considered expenses of the mother and not expenses of the child. Charges that are considered expenses of the child are paid only if the child is covered by a family enrollment. Routine circumcision is covered under Surgical Benefits for a newborn child covered by a family enrollment, pages 14 and 15.

Outpatient care

Charges of the doctor and/or State licensed midwife (for delivery, prenatal and postnatal visits) and amniocentesis are paid under Surgical Benefits, pages 14 and 15.

The Plan pays **100%** of reasonable and customary charges not subject to the calendar year or inpatient hospital deductibles for covered facility services at the time of delivery when: delivery is on an outpatient basis; delivery is at a licensed birthing center; or inpatient delivery results in a hospital confinement of one day (overnight) or less and no more than one day's room and board charge.

If the mother or newborn child is transferred from a birthing center to a hospital due to medical complications, the birthing center expenses will be paid as shown above. For a confinement of one day (overnight) or less, if the mother and child leave the hospital against medical advice, this benefit is not payable and regular Plan benefits will apply.

Section 5. Benefits *continued*

Related benefits

Diagnosis and treatment of infertility — Diagnosis and treatment of infertility are covered as Other Medical Benefits, page 21.

Testing — Sonograms, other related tests on the unborn child, and the initial examination of a newborn child are covered as Other Medical Benefits, page 20.

Voluntary sterilization — Voluntary sterilization is covered under Surgical Benefits, pages 14-15.

Well child care — Well child visits to a doctor for children up to age 18 months are covered as Other Medical Benefits, page 20. Childhood immunizations are covered as Additional Benefits, page 22.

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

What is not covered

- Reversal of voluntary surgical sterilization
- Routine sonograms to determine fetal age and/or size
- Procedures, services, drugs and supplies related to impotency, sex transformations, sexual dysfunction or sexual inadequacy
- Assisted Reproductive Technology (ART) procedures, such as artificial insemination, in vitro fertilization, embryo transfer and gamete intrafallopian transfer (GIFT), as well as services and supplies related to ART procedures
- 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

The standard benefits of this Plan apply for the out-of-network area. PPO benefits are available only in the PPO Network Area and apply only when you use a PPO Provider. If you live in the PPO area and do not use a PPO provider, non-PPO benefits apply.

Mental Conditions/Substance Abuse Benefits

What is covered — The Plan pays for the following services:

Mental conditions

Inpatient care — The Plan pays this the same as Inpatient Hospital Benefits including Other charges (see page 13). Catastrophic protection benefit applies to your covered out-of-pocket expenses for the treatment of mental conditions (see pages 36 and 37).

Precertification — The medical necessity of your admission to a hospital or other facility must be precertified for you to receive full Plan benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See pages 35 and 36 for details.

Waiver — See page 35 for exceptions to the precertification requirement.

Inpatient visits

PPO Benefits

(If you live in the PPO Network Area)

The Plan pays **90%** of reasonable and customary charges for doctors' in-hospital visits for mental conditions up to a maximum Plan payment of $60 per visit with a limit of 50 visits per calendar year.

In addition, benefits for group therapy are payable at actual charges up to a maximum of $30 per session. Group therapy is not subject to the calendar year visit limitation.

Non-PPO Benefits

(If you live in the PPO Network Area or Out of Network Area)

The Plan pays **80%** of reasonable and customary charges for doctors' in-hospital visits for mental conditions up to a maximum Plan payment of $60 per visit with a limit of 50 visits per calendar year.

In addition, benefits for group therapy are payable at actual charges up to a maximum of $30 per session. Group therapy is not subject to the calendar year visit limitation.

Charges for professional services of a doctor or any other practitioner covered under this Plan, even though billed by a hospital as part of hospital services, are covered only as specified above.

Section 5. Benefits *continued*

Outpatient care

PPO Benefits

(If you live in the PPO Network Area)

After the $250 calendar year deductible, the Plan covers outpatient care by a doctor, clinical psychologist, clinical social worker, psychiatric nurse, or a nurse practitioner/clinical specialist. The Plan pays **90%** of reasonable and customary charges (limited to 60 therapy visits per person per calendar year) for individual visits, including collateral visits if the patient is a child.

The Plan pays **90%** of reasonable and customary charges up to a maximum of $40 per session for group therapy visits. Group therapy is not subject to the calendar year visit limitation.

Non-PPO Benefits

(If you live in the PPO Network Area or Out of Network Area)

After the $250 calendar year deductible, the Plan covers outpatient care by a doctor, clinical psychologist, clinical social worker, psychiatric nurse, or a nurse practitioner/clinical specialist. The Plan pays **75%** of reasonable and customary charges (limited to 60 therapy visits per person per calendar year) for individual visits, including collateral visits if the patient is a child.

The Plan pays **75%** of reasonable and customary charges for day care in a day care center (limited to 20 visits per person per calendar year), provided the institution meets the definition on page 7.

The Plan pays **50%** of reasonable and customary charges up to a maximum of $40 per session for group therapy visits. Group therapy is not subject to the calendar year visit limitation.

Charges for psychological testing and pharmacological visits are covered only under Other Medical Benefits (see page 20). The medical management of mental conditions will be covered under this Plan's Other Medical Benefits provisions. Related drug costs will be covered under this Plan's Prescription Drug Benefits. Office visits for the medical aspects of treatment do not count toward the Plan's visits per person per calendar year maximums.

Substance abuse

The Plan will pay regular Inpatient Hospital Benefits (refer to page 13) and Other Medical Benefits (refer to page 20) for up to 5 days confinement each calendar year for detoxification in a hospital or an accredited treatment center with detoxification facilities.

The Plan also pays **100%** of charges up to $8,000 for one 28-day inpatient substance abuse treatment program in an accredited alcoholic or drug treatment facility per person per calendar year. This benefit also includes an aftercare outpatient treatment program that immediately follows the 28-day inpatient program.

Precertification

Precertification is required to obtain the above benefits for detoxification and/or treatment of substance abuse. Refer to pages 35 and 36 for additional information on how to obtain precertification.

Lifetime maximum

The Substance abuse benefit is limited to two treatment programs per person per lifetime. Withdrawal prior to completion constitutes use of one program. No other Plan benefits are available for the treatment of alcoholism or drug addiction with the exception of the detoxification benefit shown above.

What is not covered

- Counseling or therapy for marital, educational, sexual or behavioral problems

The standard benefits of this Plan apply for the out-of-network area. PPO benefits are available only in the PPO Network Area and apply only when you use a PPO Provider. If you live in the PPO area and do not use a PPO provider, non-PPO benefits apply.

Section 5. Benefits *continued*

Other Medical Benefits

What is covered

PPO Benefits

(If you live in the PPO Network Area)

After the $250 calendar year deductible has been met, the Plan pays **90%** of covered reasonable and customary charges for the following:

Non-PPO Benefits

(If you live in the PPO Network Area and Out of Network Area)

After the $250 calendar year deductible has been met, the Plan pays **80%** of covered reasonable and customary charges for the following:

- Doctors' visits (in-hospital, home, office and consultations)
- Charges by an independent consulting doctor for services in relation to a second opinion regarding the necessity for anticipated surgery
- Services of a registered physical therapist or a registered occupational therapist, practicing within the scope of the license for administration of therapy in accordance with a doctor's specific instructions as to type, frequency and duration
- Speech therapy provided by a licensed speech therapist practicing within the scope of the license, but only when necessary to restore speech when there has been a functional loss of speech due to illness or injury, and when therapy is rendered in accordance with a doctor's specific instructions as to type, frequency and duration
- Well-child visits through 18 months of age; immunizations are covered under Additional Benefits, page 22
- One pair of eyeglasses or contact lenses per incident if required to correct an impairment directly caused by accidental ocular injury or specifically ordered by the doctor in connection with a diagnosis of cataract, keratoconus or glaucoma
- X-ray services and laboratory tests
- Blood or blood plasma not donated or replaced
- Acupuncture performed by an M.D. or D.O.
- Radium or radioactive isotopes
- Artificial eyes or limbs required to replace natural eyes and limbs
- Casts, splints, trusses, braces or crutches
- Hospital outpatient services and supplies not covered under any other provision of this Plan
- Rental up to the purchase price, or purchase (at the option of the Plan), of durable medical equipment, such as wheelchair, hospital-type bed, and iron lung
- Oxygen and equipment for its administration
- Chemotherapy
- Radiation therapy
- Ambulance service to or from the hospital
- Prescription drugs purchased from a pharmacy outside of the 50 United States (see Prescription Drug Benefits page 24 for details)
- Prescriptions obtained from a doctor or other covered facility
- Dental work necessitated by accidental injury to the jaw or sound natural teeth if the accident occurs while covered by the Plan and the service is rendered while covered by this Plan within 24 months of the accident, including expenses of necessary dental X-rays and initial replacement of sound natural teeth
- Psychological tests and pharmacological visits
- Breast prostheses, including surgical bras and replacements, following a mastectomy
- Routine physical examination, limited to a maximum charge of $500 per person, per calendar year. Routine mammograms are covered separately as follows.

Routine services

In addition to coverage above of diagnostic X-rays, 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 64, one mammogram screening every calendar year; and
- At age 65 and older, one mammogram screening every two consecutive calendar years.

Section 5. Benefits *continued*

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
- One screening sigmoidoscopy every five years for members age 50 and older

Prostate cancer screening

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

Also covered as Routine services are the following:

- From age 19 through 64, one nonfasting total blood cholesterol test every three consecutive calendar years.
- At age 19 and over, one tetanus-diphtheria (Td) booster every 10 consecutive calendar years.
- At age 65 and over, one influenza vaccine and pneumococcal vaccine every calendar year.

Limited benefits

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.

This benefit includes FDA approved drugs and medicines that are intended to aid in smoking cessation. Smoking cessation drugs and medications are not available under any other Plan provisions.

Diagnosis and treatment of infertility

After the $250 calendar year deductible, the Plan pays **80%** of reasonable and customary charges, up to $5,000 per person per lifetime, for the diagnosis and treatment of infertility as defined below.

Diagnosis of infertility includes:

- The initial diagnostic tests and procedures done solely to identify the cause or causes of the inability to conceive.

Treatment of infertility includes:

- Hormone therapy and related services; and
- Medical or surgical services performed solely to create or enhance the ability to conceive.

Hormone therapy to diagnose or treat infertility is not available under any other Plan provisions.

What is not covered

- Sun or heat lamps, whirlpool baths, heating pads, air purifiers, humidifiers, air conditioners, exercise devices and other items that do not meet the definition of durable medical equipment
- Orthopedic shoes, orthotics and other supportive devices for the feet
- Provocative food testing, end-point-titration techniques and sublingual allergy desensitization
- Routine eye examinations
- Eyeglasses and contact lenses except as shown on page 20
- Eye exercises and visual training (orthoptics)
- Hearing aids and examinations for them, except the initial exam
- Inpatient private duty nursing, except as shown on page 13
- Chelation therapy, except for acute arsenic, gold, mercury or lead poisoning
- Services provided by a chiropractor (except see page 8 regarding medically underserved areas)
- Drugs and services for cosmetic purposes
- Jobst stockings, unless determined to be medically necessary by the Plan
- Assisted Reproductive Technology (ART) procedures, such as artificial insemination, in vitro fertilization, embryo transfer and gamete intrafallopian transfer (GIFT), as well as services and supplies related to ART procedures, are not covered.
- Telephone consultations
- Prescriptions purchased from a non-participating pharmacy in the 50 United States, except as shown under Prescription Drug Benefits (see page 24)
- Procedures, services, drugs and supplies related to impotency, sex transformations, sexual dysfunction or sexual inadequacy

The standard benefits of this Plan apply for the out-of-network area. PPO benefits are available only in the PPO Network Area and apply only when you use a PPO Provider. If you live in the PPO area and do not use a PPO provider, non-PPO benefits apply.

Section 5. Benefits *continued*

Additional Benefits

Accidental injury

The Plan pays **100%** of reasonable and customary charges made by a hospital or doctor for outpatient emergency treatment (with or without surgery) rendered within 72 hours after an accidental injury (see definition). Charges for services after 72 hours are covered under Other Medical Benefits. Emergency treatment is otherwise covered the same as nonemergency treatment.

Childhood immunizations

Childhood immunizations recommended by the American Academy of Pediatrics are covered at **100%** of reasonable and customary charges for covered members under age 22. Associated charges for office visits and other services will be considered under Other Medical Benefits. See page 20.

Emergency ambulance service

The Plan pays **100%** up to $50 for ambulance service within 72 hours of an accident. Charges over $50 for ambulance service are payable under Other Medical Benefits.

Home health care

When precertification is obtained (see pages 35 and 36), the Plan pays **100%** of reasonable and customary charges up to $80 per visit for a maximum of 90 home health care visits per calendar year, limited to one visit per day, if such care is an alternative to hospitalization.

When precertification is not obtained, the Plan pays **100%** of reasonable and customary charges up to $40 per visit for a maximum of 40 home health care visits per calendar year, limited to one visit per day, if such care is an alternative to hospitalization.

A home health care visit consists of one of the following:

- Less than an 8 hour shift of nursing care provided on a part-time basis by a registered nurse (RN) or a licensed practical nurse (LPN);
- One session of physical, occupational or speech therapy provided by a licensed therapist;
- One visit from a licensed social worker (limited to two visits per calendar year); or
- Less than an 8 hour shift of a home health aide's services that are performed under the supervision of a registered nurse (RN) and that consists mainly of medical care and therapy provided solely for the care of the insured person.

The above home health care services must be furnished: by a home health agency (or by visiting nurses where services of a home health agency are not available); in accord with a home health care plan (see definition) certified by the member's doctor; and in the insured person's home.

Hospice care

When precertification is obtained (see pages 35 and 36), the Plan pays **100%** of reasonable and customary charges up to a maximum of $7,500 for hospice care provided by a hospice agency or organization (see definition) to a terminally ill patient in the final stages of illness when such care is recommended by a doctor.

When precertification is not obtained, the Plan pays **100%** of reasonable and customary charges up to a maximum of $4,500 for hospice care when the above requirements are met.

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

Private duty nursing at home

For services rendered by a registered nurse (RN) or licensed practical nurse (LPN) in the home, the Plan will cover up to 500 units per calendar year. One private duty nursing unit consists of up to one hour of private duty nursing care. The Plan pays $12 per unit and no deductible applies.

Renal dialysis

The Plan pays **100%** of reasonable and customary charges for all covered services and supplies for renal dialysis in or out of a hospital.

Section 5. Benefits *continued*

Skilled nursing facilities

When precertification is obtained (see pages 35 and 36), if a person is confined in a skilled nursing facility (see definition), the Plan will, for a maximum of 60 days per confinement, pay **100%** of reasonable and customary charges when:

- the confinement is for the purpose of receiving medical care;
- the confinement is under the supervision of a doctor; and
- the confinement is an alternative to hospitalization.

When precertification is not obtained, the Plan will, for a maximum of 30 days per confinement, pay **80%** of reasonable and customary charges in a skilled nursing facility, provided the above conditions are met.

Skilled nursing facility benefits shown above will be restored for each new period of confinement. There is a new period of confinement when:

- the requirements listed above are met; and
- at least 60 days have elapsed since the insured person was last confined in a skilled nursing facility.

The standard benefits of this Plan apply for the out-of-network area. PPO benefits are available only in the PPO Network Area and apply only when you use a PPO Provider. If you live in the PPO area and do not use a PPO provider, 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 that by Federal law of the United States require a doctor's prescription for their purchase
- Insulin
- Needles and syringes for the administration of covered medications
- Diabetic, colostomy and ostomy supplies
- FDA-approved drugs, prescriptions, and devices for birth control requiring a doctor's prescription

What is not covered

- Nonprescription medicines (over-the-counter medication)
- Drugs and supplies for cosmetic purposes
- Nutritional supplements and vitamins
- Medication that under Federal law does not require a prescription, even if your doctor prescribes it or State law requires it or for which there is a non-prescription equivalent available
- Drugs to aid in smoking cessation except those limited to the $100 lifetime maximum as part of the smoking cessation benefit (see page 21). You may not obtain smoking cessation drugs with your PAID Prescription Card or through the Mail Order Drug Program. You must purchase these drugs and file the claim with the Plan.
- Hormone therapy to diagnose or treat infertility except that limited to the $5,000 lifetime maximum as part of the diagnosis and treatment of infertility benefit (see page 21). You may not obtain hormone therapy treatment with your PAID Prescription Card or through the Mail Order Drug Program.
- Drugs and supplies related to impotency, sex transformations, sexual dysfunction or sexual inadequacy

From participating pharmacies in the 50 United States

The Plan will provide you with a combination Foreign Service Benefit Plan — PAID Prescription identification card. In most cases you simply present the card together with the prescription to a participating pharmacy. You may purchase up to a 30-day supply of medication. You pay a $10.00 copayment for each generic or a $20.00 copayment for each brand name prescription drug, supply or refill. No deductible applies. Refills cannot be obtained until 75% of the drug has been used. You may not obtain more than a 30-day supply through the pharmacy arrangement. You must obtain more than 30 days supply through the Mail Order Drug Program.

Section 5. Benefits *continued*

You may fill your prescription at any pharmacy participating in the PAID TelePAID system. You may obtain the names of participating pharmacies by calling 1-800/251-7682 or on the internet at http://www.merck-medco.com or as a link through our web site at http://www.afspa.org. Each participating pharmacy has a TelePAID system that calculates your copayment. The Pharmacist receives an electronic message displaying the correct amount to charge you. You will be required to sign a signature log to prove you have received the prescription drug. You do not file a PAID prescription card claim with the Plan.

When Medicare Part B is the primary payer, the Plan does **not** waive the copayment applicable to covered drugs and supplies purchased at a participating pharmacy.

From non-participating pharmacies in the 50 United States

After the calendar year deductible of $250 is met, the Plan pays **50%** of reasonable and customary charges. Claims for prescription drugs and medicines that are purchased from a non-participating pharmacy in the 50 United States must include receipts that show the name of patient, prescription number, names of drugs and medicines, name of the prescribing doctor, name of pharmacy, date and the charge. Use the Plan's claim form to claim benefits for prescription drugs and supplies you purchased through a non-participating pharmacy in the 50 United States. You may obtain claim forms by calling 202/833-4910. Mail claims to the Plan's address on page 28.

Waiver

When Medicare Part B is the Primary payer, the Plan waives the $250 calendar year deductible. The Plan does **not** waive the **50%** coinsurance applicable to covered drugs and supplies purchased at a non-participating pharmacy.

From pharmacies outside of the 50 United States

After the $250 calendar year deductible is met the Plan pays **80%** of reasonable and customary charges. Claims for prescription drugs and medicines that are purchased from a pharmacy outside of the 50 United States must include receipts that show the name of patient, prescription number, names of drugs and medicines, name of the prescribing doctor, name of pharmacy, date and the charge. Use the Plan's claim form to claim benefits for prescription drugs and supplies you purchased through a retail pharmacy outside of the 50 United States. You may obtain claim forms by calling 202/833-4910. Mail claims to the Plan's address on page 28.

By mail

For long-term prescription needs, use the Mail Order Drug Program to receive higher benefits.

If your doctor orders more than a 30-day supply of drugs or covered supplies, up to a 90-day supply, order your prescription or refill by mail. Merck Medco Rx Services will fill your prescription. All drugs and supplies listed on the previous page are covered except for those that require constant refrigeration, are too heavy to mail, or that must be administered by physicians in a clinical setting.

If a Federally-approved generic equivalent to the prescribed drug is available, Merck Medco Rx Services will dispense the generic equivalent instead of the name brand unless your doctor specifies that the name brand is required.

You pay a $15.00 copayment for each generic prescription drug, supply, or refill you purchase by mail. You pay a $25.00 copayment for each name brand prescription drug, supply or refill you purchase by mail. No deductible applies.

When Medicare Part B is the primary payer, the Plan does **not** waive the copayment applicable to covered drugs and supplies purchased through the Mail Order Program.

To order your prescriptions by mail

The Plan will send you information on Merck Medco Rx Services. To order by mail:

1) Complete the initial mail order form;
2) Enclose your prescription and copayment;
3) Mail your order to Merck Medco Rx Services; and
4) Allow approximately two weeks for delivery.

Section 5. Benefits *continued*

You'll receive forms for refills and future prescription orders each time you receive drugs or supplies under this program. You may also order refills over the Internet directly from Merck Medco Rx Services at their website http://www.merck-medco.com. In the meantime, if you have any questions about a particular drug or a prescription, and to request your first order forms, you may call toll-free: In the United States 1-800/251-7682; from overseas 1-800/497-4641 (available in over 140 countries). If you cannot use the overseas 800 number call Merck Medco collect at 1-973/560-6100.

Drugs from other sources

Prescription drugs are also covered under this Plan when they are provided to you by a doctor or facility as specified under Other Medical Benefits (see page 20).

The standard benefits of this Plan apply for the out-of-network area. PPO benefits are available only in the PPO Network Area and apply only when you use a PPO Provider. If you live in the PPO area and do not use a PPO provider, non-PPO benefits apply.

Dental Benefits

What is covered

The Plan will pay **100%** of charges of a dentist (D.D.S. or D.M.D.) up to the amounts shown for the following dental services. The Plan will pay dental benefits for the listed procedures only.

Dental care

Preventive care, limited to two services per person per calendar year

• Oral exam	$ 13
• Prophylaxis (cleaning), adult	23
• Prophylaxis, child (thru age 14)	16
• Prophylaxis with fluoride, child (thru age 14)	26

Surgery

Apicoectomy (tooth root amputation)	$ 50 per root
Alveolectomy (excision of alveolar bone)	
4 through 12 teeth	40
13 through 20 teeth	60
21 or more teeth	80
Alveolar abscess, incision and drainage	10
Gingivectomy (excision of gum tissue) each quadrant	50

Orthodontic services

Plan pays **50%** of reasonable and customary charges for orthodontic services up to $1,000 per person in a lifetime. Orthodontics, for purposes of this benefit, is the realignment of natural teeth or correction of malocclusion.

Related benefits

Oral surgery

For covered oral surgery, including the removal of impacted teeth, see page 16.

Accidental injury to sound, natural teeth

Dental work required due to accidental injury to sound natural teeth is covered as described under Other Medical Benefits if the member was covered by this Plan when the accident occurred (see page 20).

What is not covered

- Other dental services, including dental implants, not listed as covered
- Any other expenses for covered dental services (except as shown above, and except for hospitalization when required) are not covered under any other provision of this Plan
- Treatment of temporomandibular joint (TMJ) disorders (except as provided on page 16 under Oral and maxillofacial surgery)

The standard benefits of this Plan apply for the out-of-network area. PPO benefits are available only in the PPO Network Area and apply only when you use a PPO Provider. If you live in the PPO area and do not use a PPO provider, non-PPO benefits apply.

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, copay charges, etc. These benefits are not subject to the FEHB disputed claims review procedure.

Long Term Care

Long Term Care is open to AFSPA members under the age of 80. Premium rates are based on your age at the time of acceptance into the program. The program:

- Covers confinements for skilled nursing, intermediate nursing and custodial care ($100 per day benefit).
- Covers confinement in an Assisted Living Facility ($50 per day benefit).
- Covers nonconfinement care for home health care, adult day care and respite care ($50 per day benefit).
- Contains return of premium feature.
- Contains benefit increase option.
- Contains optional automatic inflation protection rider.

Term Life Insurance

Term Life Insurance is open to all AFSPA members until age 60. The program includes:

- Up to $200,000 of coverage.
- Living Care Benefit that allows early access to a portion of your life insurance benefit in certain cases.
- Coverage for death **including acts of terrorism or declared or undeclared war**.

Expanded Dental Benefits

Expanded Dental benefit programs are open to every AFSPA member. We offer two different plans: one that is available in the D.C. metropolitan area; and one that is available overseas and anywhere in the U.S. The plans cover services such as fillings, X-rays, crowns, root canals and preventive care. Premiums are based on self-only, two party, or family enrollment, and may be paid quarterly or annually.

- CONSUMER DENTAL CARE (Available DC/MD/VA Only)
  - No claim forms
  - No deductibles
  - No limitations or lifetime maximum
  - No waiting periods for pre-existing conditions
- THE DENTAL INDEMNITY PLAN (Available overseas and anywhere in the U.S.)
  - $1,000 maximum allowance per year
  - Annual deductible ($50 per individual/$150 per family)
  - No deductible for preventive care
  - Excellent benefits

Long Distance Telephone Services

- Affordable, quality telecommunications services through Rapid Link's CommLink Calling Card and, for those overseas, Callback Service.
  - Low flat rate pricing
  - No sign-up fees
  - No monthly fees
  - 24 hour Customer Service, anytime
  - No hidden costs
  - Convenient payment options

Senior Living Services

AFSPA has a broad program for senior living alternatives. At no additional cost to our members we offer information on senior living facilities throughout the U.S.

Legal Services

Legal services are available through arrangements with four firms located in the Washington Metropolitan area. Most areas of law are practiced. Members of AFSPA are offered special rates.

Travel Assistance Services

AFSPA, in conjunction with Worldwide Assistance Services, Inc., offers a valuable product called Travel Assistance International (TAI). TAI has local representatives in practically every country in the world and can provide you with:

- Unlimited emergency medical evacuation to the nearest medical facility where you can receive treatment.
- On the spot medical payments. If you become injured or sick overseas, payment can be made instantly to the medical provider. Your only out-of-pocket expense is a standard $100.00 deductible.
- Worldwide medical referrals and medical monitoring.
- Prescription replacement assistance.
- Repatriation of remains benefit.

For more information on this service only please call 1/800/821-2828 and identify yourself as a member of AFSPA to receive special reduced member rates.

For information and written material on any of the above programs, please contact us at:

American Foreign Service Protective Association
1716 N Street, NW
Washington, D.C. 20036-2902
202/833-4910
202/833-4918 (fax)
Email: afspa@afspa.org
Web site: www.afspa.org

Benefits on this page are not part of the FEHB Contract

Section 6. How to File a Claim

Claim forms, identification cards and questions

If you do not receive your identification card(s) within 60 days after the effective date of your enrollment you may call the Plan at 202/833-4910 to report the delay. In the meantime use your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM as proof of enrollment when you obtain services. This is also the number to call for claim forms or advice on filing claims.

If you have a question concerning Plan benefits, contact the Plan at 202/833-4910 or you may write the Plan at Foreign Service Benefit Plan, 1716 N Street, NW, Washington, DC 20036. You may also contact the Plan by fax at 202/833-4918, at its website at http://www.afspa.org or by email at afspa@afspa.org.

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

How to file claims

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

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

In addition:

- A copy of the explanation of benefits (EOB) from any primary payer must be sent with your claim. See page 32 for Medicare claims.
- Bills for private duty nurses must show that the nurse is a registered or licensed practical nurse and include initial history and physical, treatment plan indicating expected duration and frequency from the attending physician and nursing notes from the provider of service.
- Claims for rental or purchase of durable medical equipment require the purchase price, a prescription and a statement of medical necessity including diagnosis and estimated length of time needed.
- Claims for physical, speech and occupational therapy require an initial evaluation and treatment plan indicating length of time needed and progress (therapy) notes for each date of service from the therapist.
- Claims for overseas (foreign) services

  Enrollees serving overseas who are covered by both this Plan and the Medical and Health Program of the Department of State should submit claims to this Plan as described above, or as directed by the Office of Medical Services, through your Administrative Office.

  Enrollees not covered by the Medical and Health Program of the Department of State should submit claims directly to this Plan as described above.

  Claims may include an English translation. The Plan will translate claims and will convert to U.S. currency using the exchange rate applicable at the time the expense was incurred if no translation or conversion is supplied by the member.
- For dental claims, complete the front side of the Plan's standard claim form and attach a copy of the dentist's itemized bill. The dentist's bill must include the name of the patient, dates of service, itemized charges and the dentist's Federal Tax I.D. number. The Plan does not have separate dental claim forms.
- For prescription drug claims, see page 24.

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

Section 6. How to File a Claim *continued*

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

American Foreign Service Protective Association
1716 N Street, NW
Washington, D.C. 20036-2902

If you are overseas and have access to Department of State pouch mail you may send your claims in care of Department of State, Washington, D.C. 20520

Plan telephone number: 202/833-4910

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 Plan will provide you with a record of expenses submitted and benefits paid for each claim that you file (explanation of benefits). It is your responsibility to keep these payment records. The Plan will not provide duplicate copies or year end summaries.

Submit claims promptly

Submit claims promptly as they are incurred. Claims should be filed within 90 days after the expense for which the claim being made was incurred but in no event later than 2 years from the date the expense in question was incurred. We can extend this deadline if 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 drafts.

Direct payment to hospital or provider of care

If you wish to authorize direct payment to a hospital, complete an assignment form which will be available at the hospital. The hospital will bill the Plan but you must also complete and forward a claim form with the physician's statement.

When more information is needed

Reply promptly when the Plan requests information in connection with a claim. If you do not respond, the Plan 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 impotency, sex transformations, sexual dysfunction or sexual inadequacy;
- Services and 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 and supplies for which no charge would be made if the covered individual had no health insurance coverage;
- Services and supplies furnished without charge; 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 and supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption;
- Services and supplies furnished or billed by a noncovered facility, except that medically necessary prescription drugs are covered;
- Services and supplies not recommended or approved by a covered provider;
- Services and supplies not specifically listed as covered;
- Services and supplies related to weight control or any treatment of obesity, except surgery for morbid obesity;
- Non-medical services such as recreational and educational therapy and nutritional counseling;
- Treatment of mental retardation and learning disabilities;
- Services for cosmetic purposes;
- Non-surgical treatment of temporomandibular joint (TMJ) dysfunction including dental appliances, study models, splints and other devices;
- 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 Plan will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived;
- Charges the enrollee or Plan has no legal obligation to pay, such as: excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 34), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 32), or State premium taxes however applied; 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+Choice plan, to this Plan; this applies whether or not you file a claim under Medicare. You must also give this Plan authorization to obtain information about benefits or services denied or paid by Medicare when we request it. It is also important that you inform the Plan about other coverage you may have as this coverage may affect the primary/secondary status of the Plan and Medicare (see page 32).

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;
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; or
5) Services are received or charges are incurred at a VA Medical Center, overseas, or on board a ship not in a U.S. port or more than six hours before arrival at, or after departure from a U.S. port, even if the ship is of U.S. registry. In certain bordering areas of Canada and Mexico, Medicare remains primary.

For purposes of this section, "employed by the Federal Government" means that you are a Federal employee and you do not hold an appointment described under Rule 6 of the following "Medicare is primary" section.

Section 8. Limitations — Rules that affect your benefits *continued*

Medicare is primary if:

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

When Medicare is primary

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

Inpatient Hospital Benefits: If you are enrolled in Medicare Part A, the inpatient hospital precertification requirement is waived, and the Plan will waive the deductible and coinsurance.

Surgical Benefits: If you are enrolled in Medicare Part B, the Plan will waive the coinsurance applicable to surgical care.

Mental Conditions/Substance Abuse Benefits: If you are enrolled in Medicare Part A, the inpatient hospital precertification requirement is waived, and the deductible and coinsurance will be waived. If you are enrolled in Medicare Part B, the outpatient deductible and coinsurance will be waived. Visit limitations and the lifetime maximum still apply.

Other Medical Benefits: If you are enrolled in Medicare Part B, the Plan will waive the deductible and coinsurance applicable to medical care and only prescription drugs obtained from a doctor or other covered facility.

Additional Benefits: If you are enrolled in Medicare Part A, the Plan will waive coinsurance applicable to skilled nursing care.

Prescription Drugs: If you are enrolled in Medicare Part B, the Plan will waive the deductible applicable to prescription drugs. If you are enrolled in Part B, the Plan will **not** waive the **50%** coinsurance applicable to prescription drugs purchased in a non-participating pharmacy in the 50 United States, the participating pharmacy copayment and the mail order copayment.

Dental Benefits: The coinsurance applicable to dental care is not waived.

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.

Section 8. Limitations — Rules that affect your benefits *continued*

When you also enroll in a Medicare+Choice plan

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

Medicare's payment and this Plan

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

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

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

If your doctor does not participate with Medicare, asks you to pay more than the limiting charge and he or she is under contract with this Plan, call the Plan. If your doctor is <u>not</u> a Plan doctor, ask the doctor to reduce the charge or report him or her to the Medicare carrier that sent you the 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. The Plan has contracted with all Medicare Part B carriers to receive electronic copies of your claims after Medicare has paid their benefits. This eliminates the need for you to submit your Part B claims to this Plan. You may call the Plan at 202/833-4910 to find out if your claims are being electronically filed. If they are not, you should initially submit your claims to Medicare. After Medicare has paid its benefits, the Plan will consider the balance of any covered expenses. To be sure your claims are processed by this Plan, you must submit the MSN form from Medicare and duplicates of all bills along with a completed claim form. The Plan will not process your claim without knowing whether you have Medicare and, if you do, without receiving the 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 the lesser of (1) our benefits in full, or (2) a reduced amount that, when added to the benefits payable by the other coverage, will not exceed 100% of covered expenses. Thus, the combined payments from both plans may not equal the entire amount billed by the provider.

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

Section 8. Limitations — Rules that affect your benefits *continued*

When others are responsible for injuries

This subrogation and right of reimbursement provision applies when you or your dependent are sick or injured as a result of the act or omission of another person or party. The Plan has the right to recover payments the Plan has made to you or your dependent from any recovery because of illness or injury caused by a third party. In addition to its right of reimbursement, the Plan is subrogated to you or your dependent's present and future claims against a third party. Third party means another person or organization.

Liability insurance and third party actions

If you or your covered dependent suffer an injury or illness through the act or omission of another, you and your dependent agree: 1) to reimburse the Plan for benefits paid by the Plan in an amount not to exceed the amount of the recovery; and 2) that the Plan is subrogated to your (or your dependent's) rights to the extent of the benefits paid, including the right to bring suit. All recoveries (whether by lawsuit, settlement, or otherwise, and regardless of how characterized) must be used to reimburse the Plan in full for benefits paid. The Plan's share of the recovery will not be reduced because you or your dependent do not receive the full amount of damages claimed, unless the Plan agrees in writing to a reduction.

If you or your dependent are injured because of a third party's action or omission: 1) the Plan will pay benefits for that injury subject to the conditions that you and your dependent a) do not take any action that would prejudice the Plan's ability to recover benefits, and b) will cooperate in doing what is reasonably necessary to assist the Plan in any recovery; 2) the Plan's right of reimbursement extends only to the amount of Plan benefits paid or to be paid because of the injury or illness; and 3) the Plan may insist upon an assignment of the proceeds of the claim or right of action against the third party and may withhold payment of benefits otherwise due until the assignment is provided. Failure to request or obtain any such assignment prior to payment of benefits by the Plan when you or your dependent are sick or injured as a result of the act or omission of a third party will not in any way diminish the Plan's rights of reimbursement and subrogation.

When you or your dependent are sick or injured as a result of the act or omission of a third party, the Plan shall have a lien on the proceeds of that claim in order to reimburse itself to the full amount of benefits it has paid or may pay. The Plan's lien shall apply to any and all recoveries for such claim, regardless of the source, whether by court order or out-of-court settlement, and shall be satisfied in full out of the proceeds of such recovery(ies) prior to the satisfaction of the claim of any individual, including, but not limited to, the Plan enrollee, covered family member(s), and/or that person's attorney.

You are required to notify the Plan promptly of any claim that you may have for damages as a result of the act or omission of a third party for which the Plan has paid or may pay benefits. In addition, you are required to notify the Plan of any recovery, whether in or out-of-court, that you or your dependent obtain and to reimburse the Plan in full for the benefits paid or to be paid by the Plan. Any reduction of the Plan's lien for payment of attorney's fees or costs associated with the lien is subject to prior approval by the Plan.

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.

Section 8. Limitations — Rules that affect your benefits *continued*

Overpayments

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

Limit on your costs if you're 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) you are enrolled in this Plan as an annuitant or as a former spouse or family member covered by the family enrollment of an annuitant or former spouse, and 3) you are not employed in a position which confers FEHB coverage.

Inpatient hospital care

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

The Plan'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 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 coinsurance.

If you go to a PPO doctor who does not participate with Medicare, you are responsible for any deductible and the coinsurance. Non-participating physicians cannot bill you more than the limiting charge (115% of the Medicare-approved amount). Unless the doctor's agreement with the Plan states otherwise, the Plan will base its payment on the limiting charge.

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

If your physician does not participate with Medicare, the Plan will still base its payment on the Medicare-approved amount. However, in most cases you will be responsible for any deductible or coinsurance 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 Plan'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 or write the Plan for assistance.

Section 9. FFS facts

Precertification

Precertify before hospital, skilled nursing facility, or hospice admission; or receiving home health care.

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.

The Plan also requires precertification for home health care, hospice care, and skilled nursing facility care. In order to receive full Plan benefits, you must precertify these services before they are rendered. Please refer to pages 22 and 23 for more information.

To precertify a planned admission, home health care, hospice care, or skilled nursing facility care:

- You, your representative, your doctor, hospital, home health agency, hospice, or skilled nursing facility must call Mutual of Omaha's Care Review Unit prior to the admission or care. The toll-free number is 1-800/228-0286.
- Provide the following information: enrollee's name and Plan identification number; patient's name, birth date and phone number; reason for hospitalization or proposed treatment; name of hospital, facility or home health agency; name and phone number of admitting doctor; and number of planned days of confinement or care.

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

For home health care, hospice care or skilled nursing facility care, when the above requirements are met, the Care Review Unit will notify the patient, the doctor, and the facility or agency that the care is, or is not, certified as medically necessary.

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

Need additional days?

A review coordinator will contact your doctor before the certified length of stay ends to determine if you will be discharged on time or if additional inpatient days are medically necessary. If the admission is precertified but you remain confined beyond the number of days certified as medically necessary, the Plan will not pay for charges incurred on any extra days that are determined to be not medically necessary by the Plan 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 page 31). Precertification is required, however, when Medicare hospital benefits are exhausted prior to using lifetime reserve days.
- You are confined in a hospital outside the 50 United States.

Maternity or emergency admissions

When there is an unscheduled maternity admission, or an emergency admission due to a condition that puts the patient's life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone 1-800/228-0286 within two business days following the day of admission, even if the patient has been discharged from the hospital. Otherwise, in-patient benefits otherwise payable will be reduced by $500.

Newborn confinements that extend beyond the mother's discharge date must also be certified. You, your representative, the doctor or hospital must request certification for the newborn's continued confinement within two business days following the day of the mother's discharge.

Other considerations

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

Section 9. FFS facts *continued*

If you do not precertify

If precertification is not obtained before admission to the hospital (or within two business days following the day of a maternity or emergency admission or, in the case of a newborn, the mother's discharge), before home health care treatment or hospice or skilled nursing facility admission, a medical necessity determination will be made at the time the claim is filed. If the Plan determines that the admission or care was not medically necessary the benefits will not be paid. However, medical supplies and services related to the inpatient admission otherwise payable on an outpatient basis will be paid.

If the claim review determines that the hospital 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 hospital admission precertified. If the claim review determines that the home health care, hospice care or skilled nursing facility admission was medically necessary, benefits will be reduced as stated on pages 22 and 23.

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

Protection Against Catastrophic Costs

For those services with coinsurance, the Plan pays **100%** of reasonable and customary charges for the remainder of the calendar year when out-of-pocket expenses for coinsurance and deductibles in that calendar year exceed $2,500 for Self Only and $3,000 for Self and Family for you and any covered family members.

Catastrophic Protection

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

- The $175 per confinement deductible you pay for non-PPO hospitals;
- The **10%** you pay for other hospital charges if you live in the Plan's PPO Network Area and use a PPO hospital or if you live outside of the Plan's PPO Network Area;
- The **10%** you pay for surgery if you live in the Plan's PPO Network Area and use a PPO provider or if you live outside of the Plan's PPO Network Area;
- The **15%** you pay for other hospital charges if you live in the Plan's PPO Network Area and use a non-PPO hospital;
- The **20%** you pay for room and board charges if you live in the Plan's PPO Network Area and use a non-PPO hospital;
- The $250 calendar year deductible under Other Medical Benefits;
- The **10%** you pay for using PPO providers;
- The **20%** you pay for using non-PPO providers;
- The **20%** you pay for purchasing prescriptions from pharmacies outside of the 50 United States or directly from doctors or other covered facilities.

The following cannot be counted toward 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 35 and 36);
- The **50%** you pay for purchasing prescriptions at a non-participating pharmacy in the 50 United States;
- Copayments you pay under the Prescription Drug Benefits; and
- Charges in excess of specific Plan allowances, or for services that exceed the number allowed.

Mental Conditions Benefit

If your out-of-pocket expenses for treatment of covered mental conditions exceed $4,000 in a calendar year for you and any covered family members, the Plan will, for the remainder of the calendar year, pay **100%** of reasonable and customary covered charges, subject to benefit maximums, where provided (see pages 18 and 19).

Section 9. FFS facts *continued*

The following expenses are included under the Mental conditions catastrophic protection benefit:

- The $175 per confinement deductible you pay for non-PPO hospitals;
- The **10%** you pay for other hospital charges if you live in the Plan's PPO Network Area and use a PPO provider or if you live outside of the Plan's PPO Network Area;
- The **15%** you pay for other hospital charges if you live in the Plan's PPO Network Area and use a non-PPO provider;
- The **20%** you pay for room and board charges if you live in the Plan's PPO Network Area and use a non-PPO provider;
- The **10%** you pay for PPO doctors in-hospital visits subject to dollar and visit limitations;
- The **20%** you pay for non-PPO doctors inhospital visits, subject to dollar and visit limitations;
- The $250 calendar year deductible
- The **10%** you pay for outpatient visits by a PPO doctor, subject to visit limitations;
- The **25%** you pay for outpatient visits by a non-PPO doctor, subject to visit limitations;
- The **25%** you pay for day care, subject to visit limitations;
- The **10%** you pay for outpatient group therapy by a PPO doctor, subject to dollar limitations; and
- The **50%** you pay for outpatient group therapy by a non-PPO doctor, subject to dollar limitations.

Expenses not included under the Mental conditions catastrophic protection benefit are:

- The amount you pay for failure to comply with the Plan's precertification requirement;
- Charges in excess of specific Plan allowances, or for services that exceed the number allowed;
- Expenses in excess of reasonable and customary charges; and
- Expenses for treatment of substance abuse (see page 19).

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

Admission

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

Assignment

An authorization by an enrollee or spouse for the Plan to issue payment of benefits directly to the provider. The Plan 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.

Section 9. FFS facts *continued*

Confinement

An admission (or series of admissions separated by less than 60 days) to a hospital as an inpatient for any one illness or injury. There is a new confinement when an admission is: (1) for a cause entirely unrelated to the cause for the previous admission; (2) for an enrolled employee who returns to work for at least one day before the next admission; or (3) for a dependent or annuitant when confinements are separated by at least 60 days.

Congenital anomaly

A condition existing at or from birth that is a significant deviation from the common form or norm. For purposes of this Plan, congenital anomalies include protruding ear deformities, cleft lips, cleft palates, birthmarks, webbed fingers or toes and other conditions that the Plan 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 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, respirations, or administration and monitoring of feeding systems.

The Plan determines which services are custodial care.

Durable medical equipment

Equipment and supplies that:

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

Effective date

The date the benefits described in this brochure are effective:

1) January 1 for continuing enrollments and for all annuitant enrollments;
2) the first day of the first full pay period of the new year for enrollees who change plans or options or elect FEHB coverage during the open season for the first time; or
3) for new enrollees during the calendar year, but not during the open season, the effective date of enrollment as determined by the employing office or retirement system.

Expense

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

1) for a service or supply that is not medically necessary; or
2) that is in excess of the reasonable and customary charge for the service or supply.

Group health coverage

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

Section 9. FFS facts *continued*

Home health care

A plan of continued care and treatment of an insured person who is under the care of a doctor, and whose doctor certifies that without home health care, confinement in a hospital or skilled nursing care facility would be required. Home health care must be provided by a public agency or private organization that is licensed as a home health agency by the State and is certified as such under Medicare.

Hospice care program

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

Medical emergency

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

Medically necessary

Services, drugs, supplies or equipment provided by a hospital or covered provider of the health care services that the Plan 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 Plan; or disorders listed in the ICD requiring treatment for abuse of or dependence upon substances such as alcohol, narcotics, or hallucinogens.

Morbid obesity

A condition in which an individual: (1) is the greater of 100 pounds or 100% over the standard weight as determined by the Plan, with complicating medical condition(s); and (2) has been so for at least five years, despite documented unsuccessful attempts to reduce under a doctor-monitored diet and exercise program.

Prosthetic appliance

A device which is surgically inserted or physically attached to the body to restore a bodily function or replace a physical portion of the body. Prosthetic appliances include such items as artificial legs, artificial hips, artificial knees, intraocular lenses and pacemakers.

Reasonable and customary

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

Sound natural tooth

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

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 202/833-4910, or write the Foreign Service Benefit Plan, 1716 N Street, NW, Washington, DC 20036. You may also contact us by fax at 202/833-4918, by email at afspa@afspa.org or visit our website at www.afspa.org.

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.

Section 10. FEHB facts *continued*

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 Worker' 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;
- As part of its administration of the Prescription Drug Benefits, the Plan may disclose information about a member's prescription drug utilization, including the names of prescribers to any treating prescribers or dispensing pharmacies; 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.

Section 10. FEHB facts *continued*

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; and
- 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 the child becomes eligible for TCC, or receives 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 that 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.

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 at 202/833-4910 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.

Index

(This Index references both covered and non-covered services and supplies.)

Notes

Summary of Benefits for the Foreign Service Benefit 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 (Code 401-Self Only; Code 402-Self and Family). All items below with an asterisk (*) are subject to the $250 calendar year deductible.

Benefits		Plan pays/provides	Page
Inpatient care	**Hospital**		
	PPO Benefit	**100%** of semiprivate room and board plus **90%** of reasonable and customary charges for other hospital services and supplies	13
	Non-PPO Benefit	After the $175 inpatient hospital deductible per person per confinement, the Plan pays **80%** of semi-private room and board charges plus **85%** of reasonable and customary charges for other hospital services and supplies	13
	Outside PPO Network Area	After the $175 inpatient hospital deductible per person per confinement, the Plan pays **100%** of semi-private room and board charges plus **90%** of reasonable and customary charges for other hospital services and supplies	13
	Surgical		
	PPO Benefit and Out of Network Area Benefit	**90%** of reasonable and customary charges	14, 15, 16
	Non-PPO Benefit	**80%** of reasonable and customary charges	14, 15, 16
	Medical		
	PPO Benefit	**90%*** of reasonable and customary charges	20
	Non-PPO and Out of Network Area Benefit	**80%*** of reasonable and customary charges	20
	Maternity	Same benefits as for illness and injury	17, 18
	Mental Conditions	Same benefits as Hospital benefits referenced above	18
	Substance Abuse	**100%** of charges up to $8,000 for one 28-day inpatient treatment program per calendar year; detoxification - 5 days confinement per calendar year	19
Outpatient care	**Hospital**		
	PPO Benefit	**90%** of reasonable and customary charges related to and rendered within 72 hours of surgery; **90%*** of reasonable and customary charges for other outpatient services and supplies	15, 16, 17, 18, 20, 21
	Non-PPO Benefit	**80%** of reasonable and customary charges related to and rendered within 72 hours of surgery; **80%*** of reasonable and customary charges for other outpatient services and supplies	15, 16, 17, 18, 20, 21
	Out of Network Area Benefit	**90%** of reasonable and customary charges related to and rendered within 72 hours of surgery; **80%*** of reasonable and customary charges for other outpatient services and supplies	15, 16, 17, 18, 20, 21
	Surgical		
	PPO Benefit and Out of Network Area Benefit	**90%** of reasonable and customary charges	15, 16
	Non-PPO Benefit	**80%** of reasonable and customary charges	15, 16
	Medical		
	PPO Benefit	**90%*** of reasonable and customary charges	20, 21
	Non-PPO and Out of Network Area Benefit	**80%*** of reasonable and customary charges	20, 21
	Maternity	Same benefits as for illness and injury	17, 18

Summary of Benefits for the Foreign Service Benefit Plan – 2000 *(continued)*

Benefits		Plan pays/provides	Page
Outpatient care *continued*	**Home Health Care**	Precertified and non-precertified benefits are payable. Refer to Additional Benefits	22
	Mental Conditions		
	PPO Benefit	**90%*** of reasonable and customary charges for individual therapy (limited to 60 visits per person per year); **90%*** of reasonable and customary charges up to a maximum of $40 per session for group therapy	19
	Non-PPO and Out of Network Area benefit	**75%*** of reasonable and customary charges for individual therapy (limited to 60 visits per person per year) and for day care visits (limited to 20 visits per person per year); **50%*** of reasonable and customary charges up to $40 per session for group therapy	19
	Substance Abuse	Aftercare treatment program immediately following inpatient confinement is paid as part of the inpatient substance abuse benefit	19
Emergency care (accidental injury)		**100%** of reasonable and customary charges for outpatient hospital and physicians' charges rendered within 72 hours after an accidental injury. Other emergency services are covered the same as non-emergency services	22
Prescription drugs		**80%*** of reasonable and customary charges for drugs from a pharmacy outside of the 50 United States; **50%*** of reasonable and customary charges for drugs from a non-participating pharmacy in the 50 United States	20, 24
		You pay $10 per generic prescription and $20 per brand name prescription for up to a 30-day supply from a participating pharmacy; you pay $15 per generic and $25 per brand name prescription for up to a 90-day supply of medication ordered and supplied by mail	23, 24, 25
Dental care		Routine preventive care and surgical procedures up to amounts shown. Orthodontics up to $1,000 per person per lifetime, at **50%** of reasonable and customary charges	25
Additional benefits		Hospice care, home health care, private duty nursing at home, childhood immunizations, renal dialysis, skilled nursing facilities, emergency ambulance service	22, 23
Protection against catastrophic costs			
	Medical/Surgical	When out-of-pocket expenses exceed $2,500 in a calendar year for Self Only and $3,000 for Self and Family the Plan pays **100%** of reasonable and customary covered charges for the remainder of that year subject to benefit maximums	36
	Mental Conditions	When out-of-pocket expenses exceed $4,000 in a calendar year for you and your family the Plan pays **100%** of reasonable and customary covered charges for the remainder of that year subject to benefit maximums	36, 37

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UNITED STATES OFFICE OF PERSONNEL MANAGEMENT

FEHB Federal Employees Health Benefits Program

2000 Rate Information for Foreign Service Benefit Plan

FEHB benefits of this Plan are described in brochure RI 72-1.

The 2000 rates for this Plan follow. If you are in a special category, refer to an FEHB Guide or contact the agency that maintains your health benefits enrollment.

		Premium			
		Biweekly		Monthly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share
Self Only	401	$ 78.83	$32.56	$170.80	$ 70.55
Self and Family	402	$175.97	$94.91	$381.27	$205.64