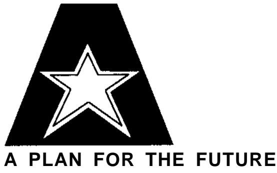
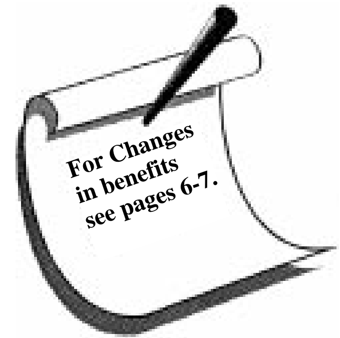


Association Benefit Plan 2000

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



Sponsored by the Association

Who may enroll in this Plan: Members of the Association

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

Enrollment code for this Plan:

421 Self Only
422 Self and Family

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

Authorized for distribution by the:

United States Office of Personnel Management

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Association Benefit Plan

Introduction

This brochure describes the benefits you can receive from the Association Benefit Plan under the Government Employees Health Association's contract (CS 1065) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. The Plan is underwritten by 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 6. 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 Association Benefit Plan as "this Plan" throughout this brochure even though in other legal documents, you see a plan referred to as a carrier.

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

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

How to use this brochure

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

1. Fee-for-Service Plan (FFS). This Plan is a FFS Plan. Turn to this section for a brief description of Fee-for-Service plans and how they work.
2. How we change for 2000. If you are a current member and want to see how we have changed, read this section.
3. How to get benefits. Make sure you read this section; it tells you how to get benefits and how we operate.
4. What to do if we deny your claim or request for service. This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.
5. Benefits. Look here to see the benefits we will provide as well as specific exclusions and limitations.
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 vary by plan. There is a detailed explanation of the benefits we offer in this brochure; you should read it carefully.

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

Section 2. How we change for 2000

Program-wide changes

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

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

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

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

Changes to the Plan

This has added the following optional hospital and physician Preferred Provider Organization (PPO) network areas:

In **Alaska**, the county of Anchorage.
In **California**, the following counties: Alameda, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Los Angeles, Madera, Marin, Mariposa, Mendocino, Merced, Mono, Monterey, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernadino, San Diego, San Francisco, San Juaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Vbentura, Yolo, and Yuba.
In **Florida**, the following counties: Brevard, Broward, Charlotte, Citrus, Collier, Dade, DeSoto, Glades, Hardee, Hendry, Hernando, Highlands, Hillsborough, Indian River, Lake, Lee, Manatee, Martin, Monroe, Okeechobee, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Saint Lucie, Sarasota, Seminole, Sumter, and Volusia.
In **Idaho**, the following counties: Benewah, Bonner, Boundary, Clearwater, Kootenai, Latah, Lewis, Nez Perce, and Shoshone.
In **Washington**, the following counties: Adams, Asotin, Benton, Chelan, Clallam, Columbia, Cowlitz, Douglas, Ferry, Franklin, Garfield, Grant, Grays Harbor, Island, Jefferson, King, Kitsap, Kittias, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, Pierce, San Juan, Skagit, Skamania, Snohomish, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, Whatcom, Whitman, and Yakima.

For enrollees residing in the PPO Network Area and using non-participating facilities or providers, the catastrophic limit is now $3,000.

For enrollees residing in the PPO Network Area who are using non-participating facilities or providers, the Plan pays 75% of the reasonable and customary charges, subject to the $250 deductible.

Copayments for prescription drugs purchased at a pharmacy have been increased as follows:

- $12 for generic drugs or brand name when generic drugs are not available.
- $24 for brand name drugs when generic drugs are available.

Copayments for prescription drugs purchased by mail have been increased as follows:

- $17 for generic drugs or brand name when generic drugs are not available.
- $34 for brand name drugs when generic drugs are available.

For Medicare B enrollees, copayments now are required for generic prescription drugs or brand name drugs when generic drugs are not available. Copayments are as follows:

- When purchased from a pharmacy, $5 copay is required for generic drugs or brand name drugs when generic drugs are not available.
- When purchased by mail, $10 copay is required for generic drugs or brand name drugs when generic drugs are not available.

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: pre-certification of all inpatient admissions and the flexible benefits option. Some include managed care options, such as PPO's, to help contain costs.

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.

Pre-certification

Pre-certification evaluates the medical necessity of proposed admissions and the number of days required to treat your condition. You are responsible for ensuring that the pre-certification requirement is met. You or your doctor must check with Mutual of Omaha's Care Review Unit before being admitted to the hospital. If that doesn't happen, your Plan will reduce benefits by $500, except for Hospice Care, Skilled Nursing Facility Care, and Home Health Care where failure to pre-certify will result in disqualification of higher paid benefit levels. Be a responsible consumer. Be aware of your Plan's cost containment provisions. You can avoid penalties and help keep premiums under control by following the procedures specified on page 44 of this brochure.

Flexible benefits option

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

PPO

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

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 $250 in covered charges you must pay each year before the Plan starts paying Other Medical Benefits. Other charges also apply to this deductible: covered inpatient and outpatient visits for the treatment of mental conditions and visits for extended

dental treatment of accidental dental injuries. You are responsible for the payment of all charges that are applied to the calendar year deductible. There is a separate calendar year deductible for each member of your family.

Family limit

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

Hospital Admission

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

Carryover

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

Coinsurance

Coinsurance is the stated percentage of covered charges you must pay after you have met any applicable deductible. The Plan will base this percentage on either the billed charge or the reasonable and customary charge, whichever is less. For instance, when a Plan pays 85% of reasonable and customary charges for a covered service, you are responsible for 15% of the reasonable and customary charges, i.e., the coinsurance. In addition, you may be responsible for any excess charge over the Plan's reasonable and customary allowance. For example, if the provider ordinarily charges $75 for a service but the Plan's reasonable and customary allowance is $60, the Plan will pay 85% of the allowance ($51). You must pay the 15% coinsurance ($9), plus the difference between the actual charge and the reasonable and customary allowance ($15), for a total member responsibility of $24.

If provider waives your share

If a provider routinely waives (does not require you to pay) your share of the charge for services rendered, the Plan is not obligated to pay the full percentage of the amount of the charge it would otherwise have paid of the provider's original charge. A provider or supplier who routinely waives coinsurance, copayments or deductibles is misstating the actual charge. This practice may be in violation of the law. The Plan will base its percentage on the fee actually charged. For example, if the provider ordinarily charges $100 for a service but waives the 10% coinsurance, the actual charge is $90. The Plan will pay $81 (90% of the actual charge of $90).

Copayment

A copayment is the stated amount the Plan may request you to pay for a covered service; such as $17 copay per prescription by mail.

Lifetime maximums

Substance abuse coverage is limited to three inpatient or outpatient treatment programs (including aftercare) per person per lifetime. See page 25.

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

One smoking cessation program per person is covered per lifetime. See page 28.

Diagnosis and treatment of infertility has a lifetime maximum benefit of $5,000. See page 28.

Do I have to submit claims?

You usually do not have to submit claims to us if you use preferred providers. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims no more than two years after the date the expense was incurred. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

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

Who provides my health care?

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

Covered facilities

Birthing Center

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

Day care Center

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

Hospice

A facility that meets all of the following:

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

Hospital

1) An institution that is accredited as a hospital under the hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or
2) Any other institution that is operated pursuant to law, under the supervision of a staff of doctors and with 24-hour-a-day nursing service, and that is primarily engaged in providing:
   a. General patient care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities, all of which facilities must be provided on its premises or under its control; or

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

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

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

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

3) is operated as a school.

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

Skilled nursing facility

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

Covered providers

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.

Qualified Clinical Psychologist

An individual who has earned either a Doctoral or Masters Clinical Degree in psychology or an allied discipline and who is licensed or certified in the state where services are performed. This presumes a licensed individual has demonstrated to the satisfaction of state licensing officials that he/she by virtue of academic and clinical experience is qualified to provide psychological services in that state.

Nurse Midwife

A person who is certified by the American College of Nurse Midwives or is licensed or certified as a nurse midwife in states requiring licensure or certification.

Nurse Practitioner/ Clinical Specialist

A person who 1) has an active R.N. license in the United States, 2) has a baccalaureate or higher degree in nursing, and 3) is licensed or certified as a nurse practitioner or clinical nurse specialist in states requiring licensure or certification.

Clinical Social Worker

A social worker who 1) has a master’s or doctoral degree in social work, 2) has at least two years of clinical social work practice, and 3) in states requiring licensure, certification or registration, is licensed, certified, or registered as a social worker where the services are rendered.

Nursing School Administered Clinic

A clinic that is: 1) licensed or certified in the state where the services are performed, and 2) provides ambulatory care in an outpatient setting—primarily in rural or inner-city areas where there is a shortage of physicians. Services billed for by these clinics are considered outpatient ‘office’ services rather than facility charges.

Physician Assistant

A person who is licensed, registered, or certified in the state where services are performed.

Licensed Professional Counselor or Master's Level Counselor

A person who is licensed, registered, or certified in the state where services are performed.

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

Coverage in Underserved Areas

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

Christian Science Practitioners

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

PPO Arrangements

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

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

This Plan's PPO

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

When you use a PPO provider

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

1) a part of a health care facility; or

2) the furnishing of certain covered services.

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

When you use a non-PPO provider

Enrollees who reside in the PPO Network Area who elect to use the services of a non-PPO provider facility will be required to pay a $100 per admission per person deductible if confined in a non-PPO facility. The Plan will then pay 75% of covered charges for a semi-private room and board rate and other hospital charges until the member's out-of-pocket costs equal $3,000, as defined on pages 45-46. 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 75% of reasonable and customary covered charges, subject to the deductible when applicable.

PPO Network Area

Alaska: County of Anchorage.
California: Counties: Alameda, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Note, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Los Angeles, Madera, Marin, Mariposa, Mendocino, Merced, Mono, Monterey, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernadino, San Diego, San Francisco, San Juaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Vbentura, Yolo, and Yuba.
District of Columbia
Florida: Counties: Brevard, Broward, Charlotte, Citrus, Collier, Dade, DeSoto, Glades, Hardee, Hendry, Hernando, Highlands, Hillsborough, Indian River, Lake, Lee, Manatee, Martin, Monroe, Okeechobee, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Saint Lucie, Sarasota, Seminole, Sumter, and Volusia.
Idaho: Counties: Benewah, Bonner, Boundary, Clearwater, Kootenai, Latah, Lewis, Nez Perce, and Shoshone.
Maryland: Counties: Anne Arundel, Baltimore, Carroll, Cecil, Charles, Frederick, Harford, Howard, Montgomery, Prince Georges, Queen Annes, St. Marys. City: Baltimore.
Virginia: Counties: Accomack, Albemarle, Amelia, Arlington, Augusta, Brunswick, Charles City, Chesterfield, Culpeper, Cumberland, Dinwiddie, Essex, Fairfax, Fauquier, Fluvanna, Gloucester, Goochland, Greene, Greenville, Hanover, Henrico, Isle of Wight, James City, King and Queen, King William, Lancaster, Loudoun, Louisa, Lunenburg, Madison, Mathews, Mecklenburg, Middlesex, Nelson, New Kent, North Hampton, Northumberland, Nottoway, Orange, Powhatan, Prince Edward, Prince George, Prince William, Richmond, Southampton, Spotsylvania, Stafford, Surry, Sussex, Westmoreland, York. Cities: Alexandria, Charlottesville, Chesapeake, Colonial Heights, Emporia, Fairfax, Falls Church, Franklin, Hampton, Hopewell, Manassas, Newport News, Norfolk, Petersburg, Portsmouth, Richmond, Suffolk, Virginia Beach, Williamsburg.

Washington: Counties: Adams, Asotin, Benton, Chelan, Clallam, Columbia, Cowlitz, Douglas, Ferry, Franklin, Garfield, Grant, Grays Harbor, Island, Jefferson, King, Kitsap, Kittias, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, Pierce, San Juan, Skagit, Skamania, Snohomish, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, Whatcom, Whitman, and Yakima.

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

Outside the Network Area

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

The Plan will pay 85% of reasonable and customary covered doctor charges, subject to the deductible when applicable.

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

First, call our customer service department at 800/634-0069. 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 apply only 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?

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

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

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

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

What should I do before filing a disputed claim?

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

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

1. Be in writing;
2. Refer 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. Arrange for a health care provider to give you the service; or
4. Approve your request for pre-authorization.

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

When may I ask OPM to review a denial?

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

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

Call us (800/634-0069) and we will expedite our review.

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

If we expedite your review due to a serious medical condition and deny your request we will inform OPM so that they can give your 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 additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What do I send to OPM?

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

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

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

Who can make the request

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

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

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.

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, DC 20044.

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.

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

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 Hospitial Benefits

What is covered The Plan pays for inpatient hospital services as shown below.

Pre-certification The medical necessity of your hospital admission must be pre-certified for you to receive full Plan benefits. Emergency admissions not pre-certified 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 44-45 for details.

Waiver This pre-certification requirement does not apply to persons whose primary coverage is Medicare Part A, another insurance policy, or when the hospital admission is outside the continental United States, Alaska and Hawaii. For information on when Medicare is primary, see page 39.

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

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

Non-PPO benefit If your permanent address is inside the PPO Network Area, 75% of covered charges after the $100 deductible per hospital admission.

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

Catastrophic protection The enrollee's share of covered charges at a non-PPO facility will be covered in full when; 1) that enrollee's calendar year deductible is met, and; 2) applicable expenses of that enrollee and any other family members exceed the catastrophic protection limit described on pages 45-46.

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

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

Limited benefits

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

1) are related to a covered hospital confinement;

2) are accepted by the hospital instead of tests that would have been performed during the confinement; and

3) are repeated only if the patient's medical record shows the pre-admission test results and the need for repeated tests upon admission.

Hospitalization for dental work

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

Related benefits

Professional charges

Charges for the professional services of a doctor or any other practitioner covered by this Plan, even though billed by a hospital as part of the hospital services, are covered under Surgical Benefits or Other Medical Benefits. See pages 21-22 and 26-28.

Skilled nursing care

See Additional Benefits, page 30.

Take-home items

Drugs and medicines furnished upon discharge for use at home are covered only under Prescription Drug Benefits. See pages 32-33. Medical supplies furnished upon discharge for use at home are covered only under Other Medical Benefits. See page 27.

What is not covered

- Confinement in nursing homes, rest homes, places for the aged, convalescent homes, or any place that is not a hospital, skilled nursing facility, or hospice. See definitions on pages 10-11.
- Custodial care (as defined on page 47) even when provided by a hospital
- A hospital admission that is not medically necessary, i.e., the medical services did not require the acute hospital inpatient (overnight) setting, but could have been provided in a doctor's office, the outpatient department of a hospital, or some other setting without adversely affecting the patient's condition or quality of medical care rendered
- Inpatient hospital services and supplies for surgery not covered by the Plan
- Inpatient private duty nursing
- Personal comfort services of a luxury nature such as radio, television, telephone, beauty and barber services

Surgical Benefits

PPO Surgical Benefits for Enrollees Residing in the Network Area

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

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

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

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

Non-PPO Surgical Benefits for Those Residing in and out of the Network Area

Hospital inpatient For enrollees residing in the PPO Network Area: The Plan pays 75% of the reasonable and customary charges for inpatient surgical services and procedures.

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

Outpatient For enrollees residing in the PPO Network Area: 75% of the reasonable and customary charges for outpatient surgery performed at a hospital, doctor's office or surgicenter. Directly related services and supplies rendered at the time of the surgery are paid at 100% of the reasonable and customary charge.

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

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

Multiple surgical procedures When multiple or bilateral surgical procedures that add time or complexity to patient care are performed during the same operative session, the Plan pays the value of the major procedure, plus 50% of the value of the lesser procedure(s) at the applicable percentage rate of the covered charges. For certain surgical procedures, a value of less than 50% may be applied for subsequent procedures.

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

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

Second opinion (voluntary) Covered under Other Medical Benefits. See page 26.

Organ/tissue transplants and donor expenses

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

What is covered

— Cornea, heart, kidney, liver, pancreas, heart/lung, single lung and double lung transplants

— Bone marrow and stem cell support as follows:

  — Allogeneic donor bone marrow transplants

  — Autologous bone marrow transplants (autologous stem cell support and peripheral stem cell support) for acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, breast cancer, multiple myeloma, epithelial ovarian cancer, and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors

— Related medical and hospital expenses of the donor when the recipient is covered by the Plan. Recipient means an insured person who undergoes an operation to receive an organ transplant. Donor means a person who undergoes an operation for the purpose of donating an organ for transplant surgery.

— 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.

What is not covered

Transplants not listed as covered.

Oral and maxillofacial surgery

80% of the reasonable and customary charges for:

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

What is not covered

- Cosmetic surgery (as defined on page 47) except for the repair of accidental injuries sustained while covered under the FEHB Program, to correct congenital anomalies as defined on page 47,
- Radial keratotomy, or similar surgery to treat myopia (except for cornea graft)
- Removal of corns or calluses, or the trimming of toenails and similar routine treatment ofconditions of the foot
- Reversal of voluntary surgical sterilization

Maternity Benefits

What is covered

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

Inpatient hospital

Pre-certification

The medical necessity of your hospital admission must be pre-certified for you to receive full Plan benefits. Unscheduled or emergency admissions not pre-certified 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 pre-certified. If any of the above are not done, the benefits payable will be reduced by $500. See page 44 for details.

Waiver

See page 44 for instances when pre-certification is not required.

Room and board and other charges

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

PPO Benefit

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

Non-PPO Benefit

If you reside in the PPO Network Area, 75% of covered charges after the $100 per admission deductible.

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

Outpatient Care

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

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

Limitations

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

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

Obstetrical care

For a confinement of 2 or more days, charges of the doctor and/or State licensed midwife (for delivery, prenatal and postnatal visits, or abortion) are paid under Surgical Benefits, pages 21-22.

Newborn care

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

Non-PPO benefits—If you reside in the PPO Network Area, 75% of reasonable and customary charges for the initial, routine, inhospital examination of a newborn infant, not subject to the calendar year deductible. Routine circumcision for an infant covered under a Self and Family enrollment is covered under Surgical Benefits.

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

Related benefits

Diagnosis and treatment of infertility

Services for the diagnosis and treatment of infertility are covered under Other Medical Benefits. See page 28.

Tests

Sonograms and other related tests on the unborn are covered under Other Medical Benefits. Amniocentesis is covered under Surgical Benefits, pages 21 and 22.

Voluntary sterilization

Covered under Surgical Benefits; see page 21.

Contraceptive Drugs

Contraceptive drugs and devices dispensed by a retail pharmacy or obtained through the Mail Order Program are covered as prescription drugs (see page 33).

For whom

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

What is not covered

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

Mental Conditions/Substance Abuse Benefits

What is covered

Mental Conditions Inpatient Care

Pre-certification

The medical necessity of your admission to a hospital or other covered facility must be pre-certified for you to receive full Plan benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See page 44 for details.

Waiver

See page 19 for when pre-certification is not required.

PPO benefit

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

Non-PPO benefit

If you reside in the PPO Network Area, 75% of covered hospital charges after the $100 deductible per admission. Catastrophic protection applies; see page 45.

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

Inpatient and Outpatient psychiatric sessions

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

Outpatient care

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

Substance abuse

Up to $10,500 per calendar year for a 28-day inpatient treatment program (including detoxification and aftercare) or up to $4,000 per year for an outpatient treatment program (and aftercare) in a facility as defined on pages 10 and 11. Inpatient confinements must be pre-certified by the Plan. For pre-certification, contact the Plan at 800/634-0069.

Lifetime maximum

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

What is not covered

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

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

Any provider not specifically listed as covered.

Other Medical Benefits

PPO Benefits

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

—Conditions

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

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

1. Supplies provided by the physician.
2. Services ordered by the physician but billed by another provider. See "Other Benefits" listed below.

Non-PPO Benefits

For enrollees residing in the Network Area: After the $250 calendar year deductible has been met, the Plan pays 75% of the reasonable and customary charges for services and supplies listed above, to the extent they are not paid under any other benefit of the Plan.

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

Other Benefits

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

- Outpatient, inpatient, and out-of-hospital X-ray and laboratory services performed by or under the supervision of a doctor. See page 30 for coverage of emergency treatment of accidental injury.
- Doctors' visits (inhospital, home, office) that are unrelated to surgery or maternity, including a second surgical opinion by an independent consulting doctor other than the surgeon.

- Private duty nursing out-of-hospital. Charges for full-time nursing or visits by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) are covered only when:
  - the care is ordered by the attending doctor, and
  - the doctor identifies the specific professional nursing skills that the patient requires, as well as the length of time needed.
- Services and supplies, either in or out of a hospital, that are recommended by the attending doctor:
- Orthopedic braces, canes, casts, cervix collars, cervical traction kits, crutches, splints and trusses
- Services and for renal dialysis and chemotherapy
- Two wigs per lifetime, up to a maximum of $150 each and not subject to the deductible, when required due to hair loss in connection with chemo or radiation therapy
- Radium, radio radioactive isotopes, and X-ray therapy
- Oxygen and rental of equipment for its administration
- Local ambulance service (above the $50 covered under Additional Benefits) or, if a special and unique hospital treatment is required that is not available locally, transportation by professional ambulance, railroad or commercial airline on a regularly scheduled flight, within the United States or Canada, to the nearest hospital equipped to furnish the treatment. This benefit does not apply to transportation necessary to obtain the services of a specific doctor or any other practitioner.
- Rental (up to the purchase price, at the option of the Plan) or purchase of durable medical equipment; including items such as wheelchairs, hospital beds, respirators and other items that the Plan determines are durable medical equipment. See definition on page 48. Durable medical equipment must be preapproved by the Plan before purchase or rental in excess of 30 days.
- Services of a registered physical therapist or a registered occupational therapist, practicing within the scope of the license, for administration of therapy in accordance with a doctor's specific instructions as to type, frequency, and duration
- Speech therapy provided by a licensed speech therapist practicing within the scope of the license, but only when necessary to restore speech when there has been a functional loss of speech due to illness or injury, and when therapy is rendered in accordance with a doctor's specific instructions as to type and duration
- Artificial eyes and limbs required to replace natural eyes and limbs.
- One pair of eyeglasses or contact lenses per lifetime, and examination for them, if required to correct an impairment directly caused by accidental eye injury or eye surgery. The services must be received within one year of the date of accident or surgery.
- One hearing aid and examination per lifetime if required to correct an impairment directly caused by accidental injury or intra-aural surgery. The expenses must be incurred within one year of the date of the accident or surgery.

- Two external breast prostheses, and two bras per calendar year following mastectomy and designed exclusively for use with an external prosthesis
- Blood or blood plasma (not donated or replaced) and its administration
- One tetanus-diphtheria (TD) booster every 10 years for patients over 19 years of age; one pneumococcal (pneumonia) vaccine per year for patients age 65 years and over; and one influenza (flu) vaccine per year per person

Limited benefits

Diagnosis and treatment of Infertility

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

1. the initial diagnostic test and procedures done solely to identify the cause or causes of the inability to conceive;
2. hormne therapy, FDA-approved drugs and related services; and
3. medical or surgical services performed solely to create or enhance the ability to conceive.

Smoking cessation benefit

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

Well child care

After the $250 calendar year deductible has been met, the Plan will pay applicable percentages for all routine inhospital visits and all routine office visits for the child's first 24 months. Coverage for immunizations is described on page 30.

Preventative Services

Routine Physical examination

One annual routine physical examination per person to include a history and physical, chest X-ray, urinalysis, blood tests, and EKG (electrocardiogram). Also included are:

- Cervical cancer screening: Annual pap smear for women age 18 and older.
- Prostate cancer screening: Annual PSA (Prostate Specific Antigen) test for males age 40 and older
- Colorectal cancer screening: Annual fecal occult blood test for members age 40 and older; and a sigmoidoscopy every 5 years starting at age 50.
- Breast cancer screening: Mammograms are covered for women age 35 and older as follows:
    - From age 35-39, one baseline mammogram during this five year period.
    - From age 40-45, one mammogram screening every other calendar year.
    - From age 45+, one mammogram every calendar year.

Benefits levels are indicated below:

PPO Benefits

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

Non-PPO Benefits

For enrollees residing in the Network Area: 75% of reasonable and customary charges, subject to the $250 deductible.

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

What is not covered

- 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
- Services of a private duty nurse whose duties consist primarily of custodial care
- Orthopedic shoes, orthotics, and other supportive devices for the feet
- Provocative food testing, end point titration techniques, hair analysis, and sublingual allergy desensitization
- Preventative medical care and services (including periodic checkups and immunizations such as polio, flu, mumps, and smallpox shots), except as provided under the Routine physical exam and Childhood immunizations benefits on page 30, and under the Well child care on page 28.
- Eyeglasses, contact lenses, or examinations for them (except as specified on page 27) and eye refractions.
- Hearing aids or examinations for them (except as specified on page 27)
- Weight control or any treatment of obesity except surgery for morbid obesity (as defined on page 49)
- Services and supplies for cosmetic purposes except for wigs as described on page 27
- Services of a chiropractor
- Chelation therapy except for acute arsenic, gold, mercury, or lead poisoning
- Speech therapy for congenital disorders or loss/impairment due to mental, psychoneurotic and personality disorders
- Assisted Reproductive Technology (ART) procedures that enable a woman with otherwise untreatable infertility to become pregnant through any artificial conception procedures such as artificial insemination, in vitro fertilization, embryo transfer and GIFT, including services and supplies related to ART procedures

Additional Benefits

Accidental injury

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

Ambulance

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

Childhood immunizations

100% of reasonable and customary charges for childhood immunizations recommended by the American Academy of Pediatrics, for covered members under age 22. Inactivated poliovirus vaccine (IVP) at 2 and 4 months is recommended. For the third and fourth doses, either IVP or oral poliovirus can be administered.

Home health care

If pre-certified, as defined on page 44, the Plan will pay up to $80 per visit for up to 90 home health care visits in a calendar year.

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

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

1) less than an 8-hour shift of nursing care, or
2) one therapy session, or
3) less than an 8-hour shift by a home health aide.

The following services are covered:

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

The above home health care services must be furnished:

1) by a home health care agency (or by visiting nurses when services of a home health care agency are not available);
2) in accordance with a home health care plan (as defined on page 49); and
3) in the patient's home.

Hospice care

If pre-certified, as defined on page 44, the Plan pays **100%** of reasonable and customary charges for covered medical expenses up to a lifetime maximum of $7,500, for care provided by an independent hospice administration to a terminally ill patient in the final stage of illness when a hospice care program, as defined on page 49, is recommended by a doctor.

If not pre-certified, as defined on page 44, the maximum allowable benefit is $4,500 for care as described above.

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

Skilled nursing facilities

If pre-certified, as defined on page 44, the Plan will pay **100%** of reasonable and customary charges for medically necessary inpatient services, for a maximum of 60 days, when the confinement is under the supervision of a doctor.

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

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

Prescription Drug Benefits

What is covered

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

— Drugs, vitamins and minerals that by Federal law of the United States require a doctor's prescription for their purchase.
— Insulin
— FDA-approved drugs and devices requiring a doctor's prescription for the purpose of birth control.

You may also purchase the following supplies that do not require a prescription by using your card:

— Diabetic, colostomy, and ostomy supplies
— Needles and syringes for the administration of covered medications.

What is not covered

— Medical supplies such as dressings and antiseptics.
— Drugs and supplies for cosmetic purposes.
— Medication that does not require a prescription under Federal law even if your doctor prescribes it or a prescription is required under your State law or for which there is a nonprescription equivalent available.
— Nutritional supplements and vitamins (including prenatal) that do not require a prescription.
— Drugs to aid in smoking cessation are covered only under the Smoking Cessation benefit.
— Fertility drugs are covered only under the Diagnosis and Treatment of Infertility benefit.

From a Pharmacy

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

- copay of $12 per generic drug or brand name, if a generic drug is not available.
- copay of $24 per brand name drug when required by your physician, or if you request, but your doctor does not require, a brand name drug and a generic equivalent is available.

Prescription refills will be covered when no more than 25% of the day's supply remains based on your doctor's prescription.

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

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

Medicare B

When Medicare Part B is the primary payer, a $5 copay will be required for a generic drug or brand name when generic is not available. Neither the copay of $24 you are required to pay for the election of a brand name drug when generic is available nor the $5 copay will be reimbursed by the Plan.

By mail

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

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

- copay of $17 per generic or brand name, if generic drug is not available.
- copay of $34 per brand name drug when required by your physician, or if you request but your doctor does not require, a brand name drug and a generic equivalent is available.

Medicare

When Medicare Part B is the primary payer, a $10 copay will be required for a generic drug or brand name when generic is not available. Neither the copay of $34 you are required to pay for the election of a brand name drug when generic is available nor the $10 copay will be reimbursed by the Plan.

To claim benefits

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

1) Complete the initial mail order form.

2) Enclose your prescription and copayment.

3) Mail your order to:

Express Scripts, Inc.
P.O. Box 27226
Albuquerque, NM 87125-9908

Allow approximately two to three weeks for delivery.

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

Purchasing drugs when you are overseas

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

Drugs from other sources

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

Dental Benefits

What is covered

The Plan pays only for the following services:

- Up to $39 for a routine oral examination including X-rays, cleaning, diagnosis, and preparatio of a treatment plan. This is limited to two exams per person per calendar year. For the purpose of this benefit, a routine oral exam, X-rays, and cleaning includes treatment to maintain the dental health of a patient.
- Up to the amounts specified below for dental fillings:

One surface $12

Two surfaces $19

Three or more surfaces $24

Related benefits

Accidental dental injury

The Plan pays **100%** of **outpatient** hospital or **outpatient** doctors' reasonable and customary charges for emergency treatment of accidental dental injury (not from biting or chewing)to the jaw or sound natural teeth and associated X-ray and laboratory expenses if rendered within 96 hours of injury. (Related follow-up care received after 96 hours is not payable under this benefit.) See page 47 for definition of accidental injury and page 50 for definition of sound natural tooth.

Extended dental treatment

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

Oral surgery

For covered oral surgery, see page 21.

What is not covered

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

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, call the Carrier at 800/634-0069, to report the delay. In the meantime, use your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM as proof of enrollment when you obtain services. This is also the number to call for claim forms or advice on filing claims. If you have a question concerning Plan benefits, contact the Carrier at 800/634-0069 or you may write the Carrier at Mutual of Omaha, P.O. Box 668587, Charlotte, NC 28266. You may also contact the Carrier by fax at 704/853-7911.

How to file claims

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

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

In addition:

- A copy of the explanation of benefits (EOB) from any primary payer (such as Medicare) must be sent with your claim.
- Bills for private duty nurses must show that the nurse is a registered or licensed practical nurse and must include nursing notes.
- Claims for rental or purchase of durable medical equipment, private duty nursing, and physical, occupational and speech therapy require a written statement from the doctor specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and medicines must include receipts that include the prescription number, name of drug, prescribing doctor’s name, date and charge.
- Use the Plan’s standard claim form to file dental claims. Attach the dentist’s itemized bill. The dentist’s bill must include name of the patient, dates of services, itemized charges and the dentist’s tax I.D. number. To speed claim processing, file dental bills separately from other medical bills.
- Claims for overseas (foreign) services should include an English translation. Charges should be converted to U.S. dollars using the exchange rate applicable at the time the expense was incurred.

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

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

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

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

Records

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

Submit claims promptly

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

When more information is needed

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

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

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

We do not cover the following:

- Services, drugs or supplies that are not medically necessary;
- Services not required according to accepted standards of medical, dental, or psychiatric practice in the United States;
- Experimental or investigational procedures, treatments, drugs or devices;
- Procedures, services, drugs and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Procedures, services, drugs and supplies related to sex transformations, sexual dysfunction or sexual inadequacy;
- Services or supplies you receive from a provider or facility barred from the FEHB Program;
- Expenses you incurred while you were not enrolled in this Plan;
- Expenses furnished without charge (except as described on page 42); 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 furnished by immediate relatives or household members. Immediate relatives include spouse, parent, child, brother or sister by blood, marriage, or adoption;
- Services furnished or billed by a noncovered facility, except that medically necessary prescription drugs are covered;
- Procedures, services, drugs and supplies not specifically listed as covered; and
- Expenses you incurred before coverage under the Plan begins, or after it ends.

Benefits will not be paid for:

- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copay or coinsurance, the Carrier will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.
- excess charges for an annuitant age 65 or older who is not covered by Medicare Part A and/or Part B (see pages 39-40), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge), or State premium taxes however applied.
- Acupuncture, except when used as an anesthetic agent for covered surgery.
- Weight control or any treatment of obesity except surgery for morbid obesity (as defined on page 49).
- Custodial care.
- Educational training.
- Eye exercises and visual training (Orthoptics).

Section 8. Limitations - Rules that affect your benefits

Medicare

Tell us if you or a family member is enrolled in Part Medicare 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 Medicate+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 800/638-6833.

Coordinating benefits

The following information applies only to enrollees and covered family members who are entitled to benefits from both this Plan and Medicare. You must disclose information about Medicare coverage, including your enrollment in a Medicare prepaid plan, to this Carrier; this applies whether or not you file a claim under Medicare. You must also give this Carrier authorization to obtain information about benefits or services denied or paid by Medicare when they request it. It is also important that you inform the Carrier about other coverage you may have as this coverage may affect the primary/secondary status of this Plan and Medicare. (see pages 39-40)

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

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

1) 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;
2) 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 was the patient's primary payer on the day before he or she became eligible for Medicare Part A due to ESRD; or
3) The patient (you or a covered family member) is under age 65 and eligible for Medicare solely on the basis of disability, and you are employed by the Federal Government.

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

Medicare is primary if

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;

1) 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;
2) You are age 65 or over and (a) you are a Federal judge who retired under title 28 of the U.S. Code, (b) you are a Tax Court judge who retired under Section 7447 of title 26 of the U.S. Code or (c) you are the covered spouse of a retired judge described in (a) or (b) above;
3) 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;
4) You are enrolled in Part B only, regardless of your employment status;
5) 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);
6) 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;
7) 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
8) The patient (you or a covered family member) becomes eligible for Medicare due to ESRD after Medicare assumed primary payer status for the patient under rules 1) to 6) above.

When Medicare is primary

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

- **Inpatient Hospital Benefits:** If you are enrolled in Medicare Part A, the Plan will waive the deductible and coinsurance.
- **Surgical Benefits:** If you are enrolled in Medicare Part B, the Plan will waive the coinsurance.
- **Mental Conditions/Substance Abuse Benefits:** If you are enrolled in Medicare Part A, the Plan will waive the inpatient hospital deductible and coinsurance. If you are enrolled in Medicare Part B, the Plan will waive the deductible and coinsurance for inpatient and outpatient visits and outpatient care. Benefits will be paid up to the stated Plan limits.
- **Other Medical Benefits:** If you are enrolled in Part B, the Plan will waive the deductible and any coinsurance or copayment for each home and office visit, physician outpatient consultation, and second surgical opinion.
- **Additional Benefits:** If you are enrolled in Medicare Part B, the Plan will waive the coinsurance for mammograms and care in a skilled nursing facility.

- **Dental Benefits:** Deductibles and coinsurance applicable to extended treatment of accidental dental injuries will be waived; benefits for other care will be paid up to the stated Plan amount.

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

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

When you also enroll in a Medicare prepaid plan

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

Medicare's payment and this Plan

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

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

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

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

How to claim benefits

In most cases, when services are covered by both Medicare and this Plan, Medicare is the primary payer if you are an annuitant and this Plan is the primary payer if you are an employee.

When Medicare is the primary payer, your claims should first be submitted to Medicare. The Carrier has contracted with most Medicare Part B claims processors (also known as carriers) to receive electronic copies of your claims after Medicare has paid their benefits. This means you do not need to submit your Part B claims to the claims processor. Call the Carrier at 800/634-0069 to find out if your claims are being filed electronically. If they are not, you should initially submit your claims to Medicare. After Medicare has paid its benefits, the Carrier will consider the balance of any covered expenses. To be sure your claims are processed by this Carrier, you must submit the MSN form from Medicare and duplicates of all bills along with a completed claim form. The Carrier will not process your claim without knowing whether you have Medicare and, if you do, without receiving the MSN.

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, this Plan will pay the lesser of (1) its benefits in full, or (2) a reduced amount that, when added to the benefits payable by the other coverage, will not exceed 100% of covered expenses. When this Plan pays secondary, it will only make up the difference between the primary plan’s coverage and this Plan’s coverage. Thus, the combined payments from both plans may not equal the entire amount billed by the provider.

When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage you may have.

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

When others are responsible for injuries

Subrogation applies when you are sick or injured as a result of the act of omission of another person or party. Subrogation means the Plan’s right to recover any benefit for injuries payments made to you or your dependent by a third party’s insurer because of the injury or illness caused by a third-party.

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 provider your benefits.

Medicaid

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

Other Government Agencies

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

Overpayments

If the Carrier determines that a member's claim has been paid in error for any reason, the Carrier shall make a diligent effort to recover an overpayment to the member from the member or, if to the provider, from the provider. The Carrier may apply subsequent benefits otherwise payable to the member or to a provider on behalf of the member to offset any overpayments.

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

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

Inpatient Hospital Care

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

The Carrier's explanation of benefits (EOB) will tell you how much the hospital can charge you in addition to what the Plan paid. If you are billed more than the hospital is allowed to charge, ask the hospital to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call the Plan at 800/634-0069 for assistance.

Physician services

The Carrier's explanation of benefits (EOB) will tell you how much the hospital or physician can charge you in addition to what the Plan paid. If you are billed more than the hospital or physician is allowed to charge, ask the hospital or physician to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call the Plan at 800/634-0069 for assistance.

The Plan is required to base its payment on the Medicare-approved amount (which is the Medicare fee schedule for the service), or the actual charge, whichever is lower, the Plan will base its payment on the lower of these two amounts and you are responsible for any deductible.

If your physician does not participate with Medicare, the Plan will base its payment on the Medicare-approved amount. However, in most cases you will be responsible for any deductible, and any balance up to the limiting charge amount that a provider who does not participate with Medicare is legally permitted to bill under Medicare law (115% of the Medicare-approved amount).

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

Section 9. Fee For Service (FFS) facts

Pre-certification

Pre-certify before admission or receiving specified services

Pre-certification is not a guarantee of benefit payments. Pre-certification of an inpatient admission or or a specified service (hospice care, skilled nursing facility care, home health care) is a predetermination that, based on the information given, the admission or service meets the medical necessity requirements of the Plan. It is your responsibility to ensure that pre-certification is obtained. If pre-certification is not obtained and benefits are otherwise payable, benefits for the admission will be reduced by $500, except for Hospice Care, Skilled Nursing Facility Care, and Home Health Care where failure to pre-certify will result in disqualification of higher paid benefit levels.

To pre-certify a scheduled admission or specified service:

- You, your representative, your doctor, or your hospital must call Mutual of Omaha's Care Review Unit prior to admission. The toll-free number is 800/634-0069.
- Provide the following information: enrollee's name and Plan identification number; patient's name, birth date and phone number; reason for hospitalization, proposed treatment or surgery; name of hospital or facility; name and phone number of admitting doctor; and number of planned days of confinement.

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

You don't need to certify an admission when:

- Medicare Part A, or another group health insurance policy, is the primary payer for the hospital confinement (see page 39). Pre-certification is required, however, when Medicare hospital benefits are exhausted prior to using lifetime reserve days.
- You are confined in a hospital outside the United States and Puerto Rico.

Maternity or emergency admissions

When there is an unscheduled maternity admission or an emergency admission due to a condition that puts the patient's life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone 800/634-0069 within two business days following the day of admission, even if the patient has been discharged from the hospital. Otherwise, inpatient benefits otherwise payable for the admission will be reduced by $500.

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

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

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

If the admission is determined to be medically necessary, but part of the length of stay was found not to be medically necessary, inpatient benefits will not be paid for the portion of the confinement that was not medically necessary. However,

Other considerations

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

If you do not pre-certify

If pre-certification is not obtained before admission to the hospital (or within two business days following the day of a maternity or emergency admission or, in the case of a newborn, the mother's discharge), a medical necessity determination will be made at the time the claim is filed. If the Carrier determines that the hospitalization was not medically necessary the inpatient hospital benefits will not be paid. However, medical supplies and services otherwise payable on an outpatient basis will be paid.

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

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

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

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 if out-of-pocket expenses for the coinsurance in that calendar catastrophic costs year exceed the following catastrophic limit for you and any covered family members:

- In the PPO Network Area using Plan providers: $2,000
- In the PPO Network Area using non-Plan providers: $3,000

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

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

- The $250/$500 you pay for the calendar year deductible.

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

- Expenses in excess of reasonable and customary charges or maximum benefit limitations;
- Expenses for treatment of substance abuse or dental care including the 20% you pay for extended dental care after an accidental injury;
- Expenses for non-covered services and supplies;
- Charges in excess of specific Plan allowances, or for services that exceed the number allowed;
- PPO copayments; and
- Any amounts you pay if benefits have been reduced because of noncompliance with this Plan's cost containment requirements. See pages 44-45.

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

Carryover

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

Definitions

Accidental injury

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

Admission

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

Assignment

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

Calendar year

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

Confinement

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

1) for a cause entirely unrelated to the cause for the previous admission;

2) for an enrolled employee who returns to work for at least one day before the next admission; or

3) for a dependent or annuitant when confinements are separated by at least 60 days.

Congenital anomalies

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

Cosmetic surgery

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

Custodial care

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

1) personal care such as help in: walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing;

2) homemaking, such as preparing meals or special diets;

3) moving the patient;

4) acting as a companion or sitter;

5) supervising medication that can usually be self administered; or

6) treatment services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.

The Carrier determines which services are custodial care.

Durable medical equipment

Equipment and supplies that:

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

Effective date

The date the benefits described in this brochure are effective:

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

Expense

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

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

Experimental or investigational

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

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

Group health coverage

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

Home health care agency

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

Home health care plan

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

Hospice care program

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

Medically necessary

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

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

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

Mental conditions/ substance abuse

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

Morbid obesity

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

Reasonable and customary

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

Sound natural tooth

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

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 800/634-0069, or write to

Mutual of Omaha
Charlotte Group Claims Processing Center
PO Box 668587
Charlotte, NC 28266-8587

You may also contact us by fax at 704/853-7911, or visit our website at www.mutualofomaha.com.

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

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

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

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

When are my benefits and premiums effective?

The benefits in this brochure are effective on January 1. If you are new to this plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitant 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 stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get coverage for a disabled child 22 years of age or older who became incapable of self-support before 22.

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

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

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

Are my medical and claims records confidential?

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

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

Information for new members

Identification cards

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

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 and are 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.

You can pick a new plan,

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

How do I enroll in TCC?

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

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

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

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

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

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

How can I convert to individual coverage?

You may convert to an individual policy if:

— Your coverage under TCC or the spouse equity law ends. If you canceled your coverage or did not pay your premium, you cannot convert.

— You decided not to receive coverage under TCC or the spouse equity law; or

— You are not eligible for coverage under TCC or the spouse equity law.

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

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

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will no 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 previous 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 800/634-0069 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, DC 20415

Penalties for Fraud

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

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

Your agency may also take administrative action against you.

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Summary of Benefits for the Association 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 (codes appear on the cover of this brochure). All items below with an asterisk (*) are subject to the $250 calendar year deductible.

	Benefits	Plan pays/provides	Page
Inpatient care	**Hospital**	**PPO Network Area (as defined on page xx)**	14
		PPO benefit: 100% of covered charges with no deductible	
		Non-PPO benefit: 75% of covered charges after a $100 inpatient hospital deductible per admission	14
		Outside the PPO Network Area: 100% of medically necessary days after a **$100** inpatient hospital deductible per person per admission, for semiprivate room and other hospital charges	14
	Surgical	**PPO benefit: 90%** of covered charges	16
		Non-PPO benefit: 75% of reasonable and customary charges for those residing in the PPO Network Area. **85%** of reasonable and customary charges for those residing outside the PPO Network Area.	16
	Medical	**PPO benefit: 90%*** of covered charges	21
		Non-PPO benefit: 75%* of reasonable and customary charges for those residing in the PPO Network Area. **85%*** of reasonable and customary charges for those residing outside the PPO Network Area	21
	Maternity	Same benefits as for illness or injury	18
	Mental Conditions	**PPO benefit: 100%** of covered hospital charges with no deductible.	20
		Non-PPO benefit: 75% of room and board and all other necessary services and supplies after a $100 inpatient hospital deductible per admission; for those residing in the PPO Network Area	20
		After a $100 inpatient hospital deductible, 100% of room and board and all other necessary services and supplies per admission for up to 60 days per confinement; after 60 days, benefits are payable at 80% for those residing outside the PPO Network Area.	20
		Up to 50 inpatient and/or outpatient psychiatric treatment sessions are covered at applicable percentage and are subject to the $250 calendar year deductible	
	Substance Abuse	Up to $10,500 per 28-day program per year for inpatient treatment; treatment programs, inpatient or outpatient, are limited to three per lifetime.	20
Outpatient care	**Hospital**	**100%** for all necessary services and supplies rendered at the time of an outpatient surgical operation performed at a hospital, doctor's office or surgi-center; other outpatient services and supplies are subject to the deductible and payable at the applicable percentages.	16
	Surgical	**PPO benefit: 90%** of covered charges	16
		Non-PPO benefit: 75% of reasonable and customary charges for those residing in the PPO Network Area. 85% of reasonable and customary charges for those residing outside the PPO network area	16
	Medical	**PPO benefit:** $10 copay for physician's professional fee and **90%*** of other covered charges	21
		Non-PPO benefit: 75%* of reasonable and customary charges for thoseresiding in the PPO Network Area. **85%*** of reasonable and customary charges for those residing outside the PPO network area	21
	Maternity	Same benefits as for illness or injury	18

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

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United States Office of Personnel Management

2000 Rate Information for

Association Benefit Plan

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

		Premium			
		Biweekly		Monthly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share
Your Share	421	$78.83	$37.43	$170.80	$81.10
Self and Family	422	$175.97	$91.83	$381.27	$198.96