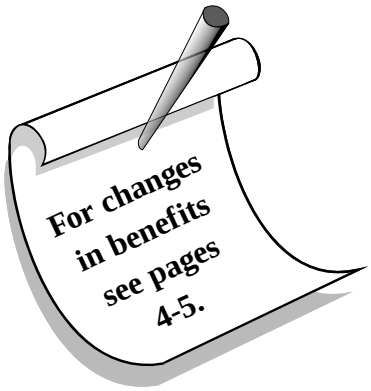
SSEHA Health Benefit Plan 2000

Managed Fee-for-Service Plan



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

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

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

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

Enrollment code for this Plan:

Y71 Self Only
Y72 Self and Family

Visit the OPM website at http://www.opm.gov/insure
and
our website at http://www.carefirst.com

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United States Office of
Personnel Management
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FEHB
Federal Employees
Health Benefits Program

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Table of Contents

Introduction

U.S. Secret Service Employees Health Association (SSEHA) Health Benefit Plan, 950 H Street, NW, Washington, DC 20001

This brochure describes the benefits you can receive from U.S. Secret Service Employees Health Association (SSEHA) Health Benefit Plan under its contract (CS2276) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This Plan is underwritten by CareFirst BlueCross BlueShield (CareFirst).

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

Because OPM negotiates benefits and premiums annually they change each year. This brochure describes the only benefits available to you under this Plan in 2000. Benefit changes are effective January 1, 2000, and are shown on page 4. You do not have a right to benefits that were available before January 1, 2000 unless those benefits are also contained in this brochure. Premiums are listed at the end of this brochure.

Plain Language

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

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

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

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

How To Use This Brochure

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

1. Fee-for-Service 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. You will also find information about non-FEHB benefits.
6. How to file a claim. Look here to find specific information on how to file claims with us.
7. General exclusions - Things we don't cover. Look here to see benefits that we will not provide.
8. Limitations - Rules that affect your benefits. This section describes limits that can affect your benefits.

How To Use This Brochure *continued*

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 to choose your own physicians, hospitals, and other health care providers.

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

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.

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

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

Changes to this Plan

Your share of the premium will increase by 10% for Self Only or 10% for Self and Family.

The Plan has changed to a new drug vendor, Advanced Paradigm, Inc. (API) for both the Retail Pharmacy and Mail Order Program. Your benefits have not changed. Please see page 31-33 for more detailed information.

Section 3. How To Get Benefits

How do I keep my health care expenses down?

You can help

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

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

Precertification

Precertification evaluates the medical necessity of proposed admissions and the number of hospital days required to treat your condition. You are responsible for ensuring that the precertification requirement is met. You or your doctor must check with your Carrier before being admitted to the hospital. If that doesn't happen, your Carrier will reduce benefits by $500. Be a responsible

Section 3. How To Get Benefits *continued*

How do I keep my health expenses down? (continued)

Precertification (continued)

consumer. Be aware of your Carrier's cost containment provisions. You can avoid penalties and help keep premiums under control by following the procedures specifies on pages 31-32 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 provisions 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.

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

Calendar year

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

Other

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

Carryover

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

Family limit

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

Coinsurance

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

Section 3. How To Get Benefits *continued*

How do I keep my health expenses down? (continued)

Copayments

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

If provider waives your share

If a provider routinely waives (does not require you to pay) your share for services rendered, the Carrier is not obligated to pay the full percentage of the amount of the charge it would otherwise have paid of the provider's original charge. A provider or supplier who routinely waives copayments or deductibles is misstating the actual charge and when doing so may be in violation of the law and subjecting you to a benefit calculated from an amount less than the misstated charge (the lesser amount being the actual charge). The Carrier will only pay the percentage of the fee actually charged. For example, if the provider ordinarily charges $100 for a service but waives the 20% coinsurance, the actual charge is $80. The carrier will pay $64 (80% of the actual charge of $80).

Lifetime maximums

- Hospice benefits are limited to 180 days per lifetime with 45 reserve days.
- Smoking cessation benefits are limited to one program per member per lifetime.

Do I have to submit claims?

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

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

Who provides my health care?

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

What is covered

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

Covered facilities

Ambulatory surgical facility

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

Extended care facility

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

Hospice

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

Hospital

A facility conforming to the standards of and accredited by the Joint Commission on Accreditation of Health Care Organizations providing inpatient diagnosis and therapeutic facilities for surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of licensed doctors of medicine (M.D.) or licensed doctors of

Section 3. How To Get Benefits *continued*

Covered facilities (continued)

Hospital (continued)

osteopathy (D.O.). The hospital must provide continuous 24-hour-a-day professional registered nursing (R.N.) services and may not be an extended care facility (other than an approved ECF); a nursing home; a place of rest; an institution for exceptional children, the aged, drug addicts, or alcoholics; or custodial or domiciliary institution having the primary purpose of furnishing food, shelter, training, or non-medical personal services. This definition includes college infirmaries and Veterans Administration hospitals.

Non-participating hospital

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

Participating hospital

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

Cancer research facility

Approved Cancer Research Facility - A facility that is:

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

Renal dialysis center

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

Covered providers

For purposes of this Plan, covered providers include:

1) a licensed doctor of medicine (M.D.) or a licensed doctor of osteopathy (D.O.);
2) a licensed or certified chiropractor, nurse anesthetist, dentist, podiatrist, occupational therapist and speech therapist practicing within the scope of their license or certification; and
3) other covered providers who may render services without the supervision of an M.D. but for whom the Carrier provides benefits include a qualified clinical psychologist, clinical social worker, optometrist, nurse midwife and nurse practitioner/clinical specialist. For purposes of this FEHB brochure, the term "doctor" includes all of these providers when the services are performed within the scope of their license or certification.

Coverage in medically underserved areas

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

Section 3. How To Get Benefits *continued*

Covered facilities (continued)

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

First, call our customer service department at 800/424-7474 extension 6039 or 202-479-6039. If you are new to the FEHB Program, we will reimburse your covered expenses. If you are currently in the FEHB Program and are switching to us, your former plan will pay for the hospital stay until:

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

These provisions only apply to the person who is hospitalized.

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

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

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

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

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

A drug, device or biological product is experimental or investigational if the drug, device or biological product cannot lawfully be 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.

Experimental or Investigational

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

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same, drug, or medical treatment or procedure. If you desire additional information concerning the experimental/investigational determination process, please contact the Plan.

Section 4. What If We Deny Your Claim Or Request For Pre-Authorization?

What should I do before filing a disputed claim?

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

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

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

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

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

If we ask your medical provider for more information, we will send you a 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 800/424-7474 extension 6039 or 202-479-6039 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.

Section 4. What If We Deny Your Claim Or Request For Pre-Authorization? *continued*

What do I send to OPM?

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

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

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

Who can make the request?

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

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

Where should I mail my disputed claim to OPM?

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

What if OPM upholds the Plan's denial?

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

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

What laws apply if I file a lawsuit?

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

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

Your records and the Privacy Act

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

Section 5. BENEFITS

Inpatient Hospital Benefits

What is covered

The Plan pays for inpatient hospital services as shown below.

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

Precertification

The medical necessity of your hospital admission must be precertified for you to receive full Plan benefits. Emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See pages 31-32 for details.

Waiver

This precertification requirement does not apply to persons whose primary coverage is Medicare Part A or another health insurance policy or when the hospital admission is outside the United States and Puerto Rico. For information on when Medicare is primary see pages 27-28.

Room and board

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

Other charges

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

Limited benefits

Pre-admission Testing

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

Related benefits

Professional charges

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

Section 5. BENEFITS *continued*

Inpatient Hospital Benefits (continued)

Take-home items

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

Renal dialysis

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

Extended care facilities

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

What is not covered

- Hospital room and board and inpatient doctor care when, in the Carrier's judgement, a hospital admission or portion of an admission is not medically necessary, i.e., the medical services did not require the acute hospital inpatient (overnight) setting, but could have been provided in a doctor's office, the outpatient department of a hospital, or some other setting without adversely affecting the patient's condition or the quality of medical care rendered
- Admissions primarily for physical therapy
- Admissions primarily for diagnostic purposes, convalescence, custodial care, rest, or rehabilitation
- Admissions for dental services covered by dental benefits

Surgical Benefits

What is covered

The Plan pays for the following services:

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

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

Hospital outpatient surgery

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

Multiple surgical procedures

When multiple or bilateral surgical procedures that add time or complexity to patient care are performed during the same operative session, the Plan pays as follows: the full allowance for the primary procedure and one half the allowance for secondary procedures. If equal procedures are performed through different incisions or body openings, the Plan pays the full allowance for the first procedure and one half the allowance for the other procedure.

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

Section 5. BENEFITS *continued*

Surgical Benefits (continued)

Incidental procedures

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

Assistant surgeon (inpatient)

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

Anesthesia

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

Organ/tissue transplants and donor expenses

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

What is covered

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

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

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

Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in non-randomized clinical trials. For the transplants covered through clinical trials, the clinical trial must be approved and funded by the National Cancer Institute (NCI) and the procedure must be conducted at an NCI approved Cancer Research Facility, (see page 8). Eligibility for non-randomized clinical trials will be determined according to NCI approved protocols. In the event non-randomized clinical trails are not available for whatever reason, the Plan will provide its regular transplant benefit in a Carrier designated facility, using eligibility criteria for NCI sponsored clinical trails.

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

Prior to approval of the procedure and the facility is required for bone marrow, heart, heart/lung, liver, singe or double lung, and pancreas transplants (see Precertification, pages 31-32).

What is not covered

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

Section 5. BENEFITS *continued*

Surgical Benefits (continued)

Oral and maxillofacial surgery

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

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

Mastectomy surgery

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

Benefits will be provided for breast reconstruction surgery following a mastectomy, including surgery to produce a symmetrical appearance on the other breast. Benefits will be provided for all stages of breast reconstruction following a mastectomy, including treatment of any physical complications, including lymphedemas, and for breast prostheses, including surgical bras and replacements.

Pre-surgical testing

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

What is not covered

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

Maternity Benefits

What is covered

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

Inpatient hospital

Precertification

The medical necessity of your hospital admission must be precertified for you to receive full Plan benefits. Unscheduled or emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Newborn confinements that extend beyond the mother's discharge must be precertified. If any of the above are not done, the benefits payable will be reduced by $500. See pages 31-32 for details.

Section 5. BENEFITS *continued*

Maternity Benefits (continued)

Room and board

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

Bassinet or nursery charges for days on which mother and child are both confined are considered hospital expenses of the mother and not expenses of the child. All other expenses of the newborn child are considered the child's own expenses and are covered only if the child is covered as a family member. Routine newborn care is covered as part of Well Child Care (see page 19).

Other charges

Charges for covered services shown on page 16 when appropriate to maternity care.

Obstetrical care

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

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

Related benefits

Diagnostic and treatment of infertility

Infertility services, including diagnostic testing and treatment, are covered under Other Medical Benefits (see page 17).

Voluntary sterilization

Voluntary sterilization is covered under surgical benefits (see pages 12-14).

For whom

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

What is not covered

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

Section 5. BENEFITS *continued*

Mental Conditions/Substance Abuse Benefits

What is covered

The Plan pays for the following services:

Inpatient Care

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

Precertification

The medical necessity of your admission to a hospital or other facility must be precertified for you to receive full Plan benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See pages 31-32 for details.

Inpatient visits

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

Catastrophic protection

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

Outpatient Care

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

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

Calendar year maximum

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

What is not covered

- Marriage or family counseling and related therapy

Other Medical Benefits

What is covered

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

- Allergy tests, injections and serum
- Artificial limbs or eyes
- Blood transfusions, including the cost of blood if not donated or replaced, blood plasma, and blood plasma expanders
- Casts, splints, braces (except corrective shoes and related devices), crutches and trusses
- Chiropractic services
- Dental care, dental surgery or dental appliances required as a result of and directly related to an accidental bodily injury occurring while the participant was covered by a FEHB Plan
- Diagnostic laboratory test and x-rays

Section 5. BENEFITS *continued*

Other Medical Benefits (continued)

What is covered (continued)

- Doctor's office, home and hospital visits
- Doctor-billed services for a medical emergency or accidental injury other than initial care rendered within 72 hours
- Dressings
- Group B streptococcus screening for pregnant women
- Growth hormone therapy
- Infertility services, including diagnostic testing and treatment
- Pre-admission testing performed more than seven days prior to admission
- Occupational therapy when rendered by a registered or licensed professional occupational therapist
- Oxygen and equipment for its administration
- Physical therapy rendered by a registered or licensed professional therapist
- Professional ambulance services within the subscriber's local area for medical emergencies
- Radiation therapy, chemotherapy, respiration therapy, and speech therapy
- Renal dialysis treatment on an outpatient basis
- Rental or, at the Carrier's option, purchase of durable medical equipment
- Take-home items billed by a hospital

Limited benefits

Cardiac rehabilitation program

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

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

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

Smoking cessation benefit

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

Other

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

Section 5. BENEFITS *continued*

Other Medical Benefits (continued)

What is not covered

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

Additional Benefits

Accidental injury and medical emergency

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

Ambulance service special benefit

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

Home health care

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

Hospice Care

What is covered

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

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

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

What is not covered

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

Section 5. BENEFITS *continued*

Additional Benefits (continued)

Flexible benefits option

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

International medical transportation

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

Routine services

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

Colorectal cancer screening

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

Prostate cancer screening

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

Breast cancer screening

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

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

Cervical cancer screening

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

Lead screening

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

Well child care

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

Childhood immunizations

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

Prescription Drug Benefits

What is covered

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

Section 5. BENEFITS *continued*

Prescription Drug Benefits (continued)

What is covered (continued)

Covered medications and accessories include:

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

What is not covered

- Drugs to aid in smoking cessation except those limited to $100 lifetime maximum as part of the smoking cessation benefit (see page 17).
- Nutritional supplements and vitamins (except injectable B-12 for treatment of pernicious anemia).
- Drugs available without a prescription.

From a pharmacy

You will be provided with an AdvanceRx Prescription identification card. In most cases, you simply present the card together with the prescription to the pharmacist. Under the Prescription Drug Card Program, you may only obtain a 30-day supply and one refill. For the initial 30-day supply and the one refill, you pay $12 for brand name and $5 for generic drugs. You may fill your prescription at a participating pharmacy. You may obtain the names of participating pharmacies by calling API Member Services at 1-800-241-3371.

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

Advance Paradigm, Inc.
P.O. Box 853901
Richardson, TX 75085-3901

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

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

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

To claim benefits

Use a claim form to claim benefits for prescription drugs and supplies you purchased (without your AdvanceRx drug card). You may obtain these forms by calling 1-800-241-3371. Follow instructions on the form and mail it to the address referenced on this page.

Section 5. BENEFITS *continued*

Prescription Drug Benefits (continued)

By mail

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

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

Waiver

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

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

1) Complete the Mail Order Form. Complete the information on the back of the pre-addressed envelope.
2) Enclose your prescription and your $12 or $5 copayment.
3) Mail your order in the pre-addressed envelope to Advance Paradigm, Inc., P.O. Box 660783, Dallas, TX 75266-0783.
4) Allow approximately two weeks for delivery.

You will receive forms for refills and future prescription orders each time you receive drugs or supplies under this Program. In the meantime, if you have any questions about a particular drug or a prescription, and to request your first order forms, you may call toll free: 1-800-241-3371 form 8 a.m. to 11 p.m. Monday through Friday, 8 a.m. to 7 p.m. on Saturday, and 8 a.m. to 5:30 p.m. on Sunday, EST. Emergency consultation is available seven days a week, 24 hours per day.

Purchasing drugs when you are overseas

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

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

As with all claims, keep a copy of your documents. Send the originals to:
Advance Paradigm, Inc.
P.O. Box 853901
Richardson, TX 75085-3901
ATTN: Correspondence

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

Section 5. BENEFITS *continued*

Dental Benefits

What is covered

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

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

Related benefits

Oral surgery

For covered oral surgery, see page 14.

What is not covered

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

Section 6. How To File A Claim

Claim forms, identification cards and questions

If you do not receive your identification card(s) within 60 days after the effective date of your enrollment you may call the Carrier at [1-800/424-7474 extension 6039 toll-free outside the Washington, D.C. area; 202/479-6039 in the Washington, D.C. area; or 1-202/479-3546 TDD Telecommunications Device for the Deaf] to report the delay. In the meantime, use your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM as proof of enrollment when you obtain services. This is also the number to call for claim forms or advice on filing claims.

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

Claim forms and detailed instructions for filing claims will be furnished with your identification card. You may obtain additional claim forms, duplicate identification cards and information about benefits from CareFirst BlueCross BlueShield.

When writing: CareFirst BlueCross BlueShield
SSEHA Health Benefit Plan
550 12th Street, SW
Washington, D.C. 20065

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

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

How to file claims

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

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

In addition:

- A copy of the explanation of benefits (EOB) from any primary payer (such as Medicare) must be sent with your claim.
- If benefits are assigned directly to the provider of care, the bill must show the provider's Tax ID Number
- Bills for psychotherapy must show length and type of each session
- Bills for private duty nursing must show that the nurse is a registered or licensed practical nurse.

Section 6. How To File A Claim *continued*

How to file claims (continued)

- Claims for rental or purchase of durable medical equipment, private duty nursing, and physical, occupational and speech therapy require a written statement from the doctor specifying the medical necessity for the service or supply and the length of time needed.
- Dental claims must be submitted with a Dental Health Plan Claim Form. Complete and sign the top portion of the form and either have the dentist fill out the bottom portion or attach the itemized bill (including the tooth number treated) to the claim form.
- Claims for surgical benefits, other medical benefits and additional benefits must be submitted with a SSEHA Health Plan Claim Form.
- Claims for overseas (foreign) services should include an English translation. Charges should be converted to U.S. dollars using the exchange rate applicable at the time the expense was incurred.

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

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

CareFirst BlueCross BlueShield
SSEHA Health Benefit Plan
550 12th Street, SW
Washington, D.C. 20065

Records

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

Submit claims promptly

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

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

Direct payment to hospital or provider of care

Bills from a participating hospital

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

The three-letter prefix “SSA” with your identification number identifies you as an SSEHA Health Benefit Plan subscriber, and advises the Blue Cross Plan in your area to contact CareFirst BlueCross BlueShield to determine what benefits should be provided. The hospital must include the three-letter prefix with you identification number when filing claims. If the services are for pre-admission testing or are related to outpatient surgery, an accidental injury or a medical emergency, please advise the hospital to include that information on the bill so that you can receive the benefits to which you are entitled. If the services rendered are in relation to mental conditions or substance abuse, an SSEHA Health Benefit Plan Claim Form must be filed as described under How to File Claims (see pages 23-24).

Section 6. How To File A Claim *continued*

Direct payment to hospital or provider of care (continued)

Bills from a non-participating hospital

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

Other facilities

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

When more information is needed

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

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;
- 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;
- Services and supplies furnished without charge (except as described on page 29-30; while in active military service; or required for illness or injury sustained on or after the effective date of enrollment (1) as a result of an act of war within the United States, its territories, or possessions or (2) during combat;
- Services and supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption;
- Services and supplies furnished or billed by a noncovered facility, except that medically necessary prescription drugs are covered;
- Services and supplies not specifically listed as covered;
- Any portion of a provider's fee or charge that is ordinarily due from the enrollee but has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible or coinsurance, the Carrier will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived;

Section 7. General Exclusions - Things We Don't Cover. *continued*

We do not cover the following (continued)

- Charges the enrollee or Plan has no legal obligation to pay, such as; excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see pages 27 - 29), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge; see page 30), or State premium taxes however applied;
- Personal comfort items;
- Convalescent or custodial care;
- Rest, institutional, or rehabilitation care not specifically stated as covered;
- Treatment of obesity; weight reduction, except surgery for morbid obesity;
- Acupuncture, except when used as an anesthesia for covered surgery;
- Biofeedback;
- Charges for stand-by services;
- Any portion of a charge which is determined by the Carrier to be in excess of the carrier allowance;
- Charges for completion of claim forms or similar charges;
- Claims for services and supplies which are filed later than two years following the date services were rendered or the supplies were provided;
- Claims for services and supplies which are filed later than two years following the date services were rendered or the supplies were provided;
- Charges for services rendered to a patient after the date of death; and
- Travel, even if prescribed by a doctor.

Section 8. Limitations - Rules That Affect Your Benefits

Medicare

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

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

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

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

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

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

Section 8. Limitations - Rules That Affect Your Benefits *continued*

Coordinating benefits

The following information applies only to enrollees and covered members entitled to benefits from both this plan and Medicare. You must disclose information about Medicare coverage, including your enrollment in a Medicare prepaid plan, to this Carrier; this applies whether or not you file a claim under Medicare. You must also give this carrier authorization to obtain information about benefits or services denied or paid by Medicare when they request it. It is also important that you inform the carrier about other coverage you may have as this coverage may affect the primary/secondary status of this plan and Medicare (see pages 27-29).

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

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

This Plan is primary if:

1) You are age 65 or over, have Medicare Part A (or Parts A and B), and are employed by the Federal Government;
2) Your covered spouse is age 64 or over and has Medicare part A (or Parts A and B) and you are employed by the Federal Government;
3) The patient (you or a covered family member) is within the first 30 months of eligibility to receive Medicare Part A benefits due to End Stage Renal Disease (ESRD) except when Medicare, based on age or disability, was the patient's primary payer on the day before he or she become eligible for Medicare Part A due to ESRD; or
4) The patient (you or a covered family member) is under age 65 and eligible for Medicare solely on the basis of disability, and you are employed by the Federal Government.

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

Medicare is primary if:

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

Section 8. Limitations - Rules That Affect Your Benefits *continued*

When Medicare is primary

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

Inpatient hospital benefits: If you are enrolled in Medicare Part A, the Plan will waive the deductible applicable to the impatient hospital care covered by Medicare Part A and this Plan.

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

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

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

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

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

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

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

If you are enrolled in Medicare, you may be asked by a physician to sign a private contract agreeing that you can be billed directly for services that would ordinarily be covered 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 form 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.

Section 8. Limitations - Rules That Affect Your Benefits *continued*

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 cost for services covered by both this Plan and Medicare Part B will depend on whether your doctor accepts Medicare assignment for the claim.

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

Doctors who do not participate with Medicare are not required to accept assignment form 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 doctors 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 Medicare limiting charge for charges of a doctor who does not participate with Medicare. The Medicare Explanation of Benefits (EOB) form will have more information about this limit.

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

How to claim benefits

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

Other group insurance coverage

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

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

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

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

Section 8. Limitations - Rules That Affect Your Benefits *continued*

When others are responsible for injuries

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

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.

Worker's compensation

We do not cover services that:

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

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

Medicaid

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

Other Government Agencies

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

Overpayments

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

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

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

Inpatient hospital care

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

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

Section 8. Limitations - Rules That Affect Your Benefits *continued*

Physician services

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

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

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

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

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

Since a physician who participate 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 participate with Medicare.

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

Section 9. FFS Facts

Precertification

Precertify before admission.

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

To precertify a scheduled admission:

- You, your representative, your doctor, or your hospital must call CareFirst BlueCross BlueShield for medical admissions, at least two days prior to admission. The toll-fre number is 1-800/999-8849 or 202/479-6718 in the Washington D.C. area. For mental health and substance abuse admissions call Health Management Strategies International, Inc. (HMS) at 1-800/553-8700 or 703/836-6365.

Section 9- FFS Facts *continued*

Precertification (continued)

- Provide the following information: enrollee's name and Plan Identification number; patient's name, birth date and phone number; reason for hospitalization, proposed treatment or surgery; name of hospital or facility; name and phone number of admitting doctor; and, number of planned days of confinement.

HMS will then tell the doctor and hospital the number of approved days of confinement for the care of the patient's condition. Written confirmation will be sent to you, your doctor, and the hospital. If the length of stay needs to be extended, follow the procedures below.

Need additional days?

A review coordinator will contact your doctor before the certified length of stay ends to determine if you will be discharged on time or if additional impatient days are medically necessary. If the admission is precertified but you remain you remain confined beyond the number of days certified as medically necessary, the Plan will not pay for charges incurred on any extra days that are determined to not be medically necessary by the Carrier during the claim review.

You don't need to certify an admission when:

- Medicare Part A, or another group health insurance policy, is the primary payer for the hospital confinement (see page 27). Precertification is required, however, when Medicare hospital benefits are exhausted prior to using lifetime reserve days.
- You are confined in a hospital outside the United States and Puerto Rico.

Maternity or emergency admissions

When there is an unscheduled maternity admission or an emergency admission due to a condition that puts the patient's life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone 1-800/999/9849 or 202/479-6718 in the Washington, D.C. area, within two business days following the day of admission, even if the patient has been discharged from the hospital. Otherwise, impatient benefits otherwise payable for the admission will be reduced by $500.

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

Other considerations

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

If you do not precertify

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

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

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

Section 9- FFS Facts *continued*

Protection Against Catastrophic Costs

Catastrophic protection

For those services with coinsurance, the Plan pays 100% of the Carrier allowance charges for the remainder of the calendar year after the calendar year deductible is met, if out-of-pocket expenses for the deductible and coinsurance in that calendar year exceed $1,000 per member or $2,000 per family enrollment.

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

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

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

- Expenses for Inpatient Hospital Benefits;
- Expenses in excess of the Carrier allowance or maximum benefit limitations;
- Expenses for mental conditions, substance abuse or dental care;
- Any amounts you pay if benefits have been reduced because of non-compliance with this Plan's cost containment requirements (see pages 4 and 31-32);
- Expenses for prescription drugs purchase through retail or mail order program.

Mental conditions/ substance abuse

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

Carryover

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

Definitions

Accidental injury

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

Admission

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

Section 9- FFS Facts *continued*

Definitions (continued)

Assignment

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

Calendar year

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

Confinement

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

Congenital anomaly

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

Cosmetic surgery

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

Covered charges

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

Custodial care

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

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

The Carrier determines which services are custodial care.

Durable medical equipment

Equipment are supplies that:

1) are prescribed by your attending doctor;
2) are medically necessary;
3) are primarily and customarily use 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.

Section 9- FFS Facts *continued*

Definitions (continued)

Effective Date

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

Experimental or investigational

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

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

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment procedure. If you desire additional information concerning the experimental/investigational determination process please contact the Plan.

Group health coverage

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

Home health care agency

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

Hospice care program

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

Maternity care

Care rendered resulting in childbirth or miscarriage.

Medical emergency

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

Section 9- FFS Facts *continued*

Definitions (continued)

Medically necessary

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

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

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

Mental conditions/ substance abuse

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

Morbid obesity

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

Reasonable and customary

The basis the Carrier uses to determine your claim payment.

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

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

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

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

Resource Based Relative Value Scale

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

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

Section 10. FEHB FACTS

You have a right to the following information.

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

If you want specific information about us, call 202/479-6039, or write to CareFirst BlueCross BlueShield, 550 12th St, S.W., Washington, D.C. 20065. You may also contact us by fax at 202/479-1544, or visit our website at http://www.carefirst.com.

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

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

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

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

When are my benefits and premiums effective?

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

What happens when I retire?

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

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

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

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

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

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

Section 10. FEHB FACTS *continued*

Are my medical and claims records confidential?

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

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

Information for new members

Identification cards

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

What if I paid a deductible under my old plan?

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

Pre-existing conditions

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

When you lose benefits

What happens if my enrollment in this Plan ends?

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

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

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

What is former spouse coverage?

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

What is TCC?

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

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

Section 10. FEHB FACTS *continued*

When you lose benefits (continued)

What is TCC? (continued)

Key points about TCC:

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

How do I enroll in TCC?

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

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

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

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

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

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

How can I convert to individual coverage?

You may convert to an individual policy if:

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

If you leave Federal service, your employing office will notify you if individual coverage is available. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Section 10. FEHB FACTS *continued*

How can I convert to individual coverage? (continued)

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

How can I get a Certificate of Group Health PlanCoverage?

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 othe coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on the information in the certificate.

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

Inspector General Advisory: Stop Health Care Fraud!

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 202/479-3708 or 800/680-9495 and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE

202/418-3300

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

Penalties for Fraud

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

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

Your agency may also take administrative action against you.

Summary of Benefits for SSEHA Health 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 with an asterisk (*) are subject to the $200 calendar year deductible.

	Benefits	Plan pays/provides	Page
Inpatient care	Hospital	100% of covered services and supplies subject to a $100 admission deductible	11-12
	Surgical	80% of covered charges*	12-14
	Medical	80% of covered charges*	16-18
	Maternity	Same as for illness or injury*	14-15
	Mental Conditions/ Substance Abuse	After the separate $200 deductible per person per calendar year; 80% of covered charges after certain out-of-pocket costs for covered expenses, reach $4,000 additional covered charges are paid at 100% for the remainder of the calendar year; inpatient benefits for substance abuse are subject to a $50,000 per calendar year per person maximum	16
Outpatient care	Hospital	100% of covered services and supplies for accidental injury (initial care), same day, surgery and pre-admission testing; 80% of other covered hospital-billed services and supplies*	11-12
	Surgical	80% of covered charges*	12-14
	Medical	80% of covered charges*	16-17
	Maternity	Same as for illness or injury*	14-15
	Home Health Care	100% of covered charges for up to 90 visits; benefits renew after 60 consecutive days without home health care or following readmission to a hospital	18
	Mental Conditions/ Substance Abuse	50% of covered charges per person per calendar year up to $2,000 per person per calendar year for substance abuse	16
Emergency care (accidental injury)		100% of covered charges for initial care rendered within 72 hours (see page 25 for coverage of follow-up care)	35
Prescription drugs			
	Retail Card Program	Member pays $5 for generic drugs, $12 for brand name drugs for initial prescription and one refill	19-21
	Mail Order Service	Member pays $5 for generic, $12 for brand name drugs up to a 90 day supply	21
Dental care		100% of covered preventative and diagnostic services, up to $1,000 per person per calendar year	22

Summary of Benefits for SSEHA Health Benefit Plan - 2000 *continued*

Benefits	Plan pays/provides	Page
Additional benefits	Ambulance service special benefit, home health care, hospice care, well child care, flexible benefits option and international medical transportation	18-19
Protection against catastrophic costs	100% of covered surgical, maternity and other medical benefits charges after a subscriber's cumulative coinsurance (inclusive of the deductible) reaches $1,000 per person or $2,000 per family for a calendar year	33
	100% of additional covered inpatient services for mental conditions/substance abuse after covered charges other than separate deductible reach $4,000 in the same calendar year; subject to $50,000 per calendar year per person maximum	33

2000 Rate Information for
U.S. Secret Service Employees Health Association

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

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

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

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
Self Only	**Y71**	**$72.94**	**$24.31**	**$158.03**	**$52.68**	**N/A**	**N/A**	**N/A**	**N/A**
Self and Family	**Y72**	**$172.85**	**$57.62**	**$374.51**	**$124.84**	**N/A**	**N/A**	**N/A**	**N/A**