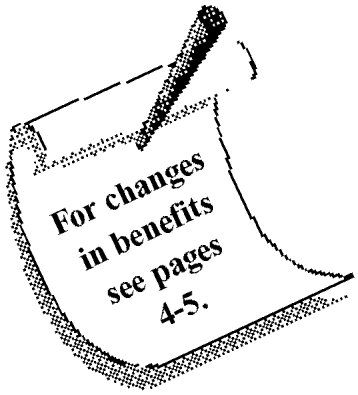
FreeState Health Plan 2000

A Health Maintenance Organization with a Point of Service Product



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

Enrollment in the Plan is limited; see page 5 for requirements.

Enrollment Code:

LD1 Self Only
LD2 Self and Family

This Plan has full accreditation from the NCQA. See the *2000 Guide* for more information on NCQA.

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

Authorized for distribution by the:

United States Office of
Personnel Management
Retirement and Insurance Service

Federal Employees
Health Benefits Program

RI 73-146

Table of Contents

	Page
Introduction	3
Plain Language	3
How To Use This Brochure	3
Section 1. Health Maintenance Organizations	4
Section 2. How We Change For 2000	4-5
Section 3. How To Get Benefits	5-7
Section 4. What To Do If We Deny Your Claim Or Request For Service	8-9
Section 5. Benefits	9-23
Section 6. General Exclusions - Things We Don't Cover	23
Section 7. Limitations - Rules That Affect Your Benefits	23-24
Section 8. FEHB FACTS	25-28
Department of Defense/FEHB Demonstration Project	28-29
Inspector General Advisory: Stop Healthcare Fraud!	30
Summary Of Benefits	Inside back cover
Premiums	Back cover

Introduction

FreeState Health Plan, Inc., 100 S. Charles Street, Baltimore, MD 21201

This brochure describes the benefits you can receive from FreeState Health Plan under its contract (CS 2010) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. 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.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on pages 4-5. Premiums are listed at the end of this brochure.

Plain Languag e

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

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

We have not re-written the Benefits section of this brochure. You will find new benefits language next year.

How To Use This Brochur e

This brochure has eight 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. Health Maintenance Organizations (HMO). This Plan is an HMO. Turn to this section for a brief description of HMOs 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 services 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. General exclusions - Things we don't cover. Look here to see benefits that we will not provide.

7. Limitations - Rules that affect your benefits. This section describes limits that can affect your benefits.

8. FEHB FACTS. Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Health Maintenance Organizations

Health maintenance organizations (HMOs) are health plans that require you to see Plan providers: specific physicians, hospitals and other providers that contract with us. These providers coordinate your health care services. The care you receive includes preventative care such as routine office visits, physical exams, well-baby care and immnuizations, as well as treatment for illness and injury.

When you receive services from our providers, you will not have to submit claim forms or pay bills. However, you must pay copayments and coinsurance listed in this brochure. When you receive emergency services or point-of-service benefits (POS) you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician or group of physicians, hospital, or other provider will be available and/or remain under contract with us. Our providers follow generally accepted medical practice when prescribing any course of treatment.

Section 2. How We Change For 2000

Program-wide changes

To keep your premium as low as possible OPM has set a minimum copay of $10 for all primary care office visits.

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

If you have a chronic or disabling condition, and your provider leaves the Plan at our request, you may continue to see your specialist for up to 90 days. If your provider leaves the Plan and you are in the second or third trimester of pregnancy, you may be able to continue seeing your OB/GYN until the end of your postpartum care. You have similar rights if this Plan leaves the FEHB program (See Section 3, How to get benefits, for more information).

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 FreeState Health Plan's premium will increase by 93% for Self Only or 26.4% for Self and Family.
- The doctor's office copay is now $10 per visit. Previously the copay was $5 per visit. This copay change also applies to visits for treatment for cleft lip and palate, outpatient short-term rehabilitative therapy, infertility treatment, both the Partial Hospitalization and the Medication Management provisions under Mental Conditions and Substance Abuse, accidental dental injury treatment, and eye exams. See page 9.
- The copay for prescription drugs is now $10 per prescription unit or refill for generic drugs and $20 per prescription unit or refill for brand name drugs. Previously, a $5 copay applied per prescription unit or refill for both generic and brand name drugs. See page 16.
- Under "Prescription Drug Benefits" provision, diet agents are now excluded. Previously, diet agents were covered. See page 16.
- Under "Prescription Drug Benefits" provision, smoking cessation drugs and medications are covered. Previously, smoking cessation drugs and medications were excluded. See page 16.

Section 2. How we change for 2000 *continued*

- Under "Prescription Drug Benefits - Limited Benefits" provision, there are specific limitations on drugs to treat sexual dysfunction. Previously, no limitations applied. See pages 16-17.
- Under "Prescription Drug Benefits - Limited Benefits" provision, one copay will apply to each month's supply of oral contraceptives. Previously, one copay applied to a 3- months supply. See pages 16-17.
- Under "Medical and Surgical Benefits" provision, benefits include general anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care provided to a plan member. Previously, no benefit was available. See pages 11-12.
- Under "Medical and Surgical Benefits" provision, coverage is available for patient cost related to a Clinical Trial as a result of treatment provided for a life-threatening condition; or prevention, early detection, and treatment studies of cancer. Previously, no coverage was available. See page 12.
- Under "Other Benefits - Vision Care" provision, there is no out-of-network benefit for routine vision correction frames and lenses. Previously, an out-of-network benefit existed. See page 19.

Section 3. How To Get Benefits

What is this Plan's service area

To enroll with us, you must live or work in our service area. This is where our providers practice. Our service area is: Maryland; Washington, DC; Northeastern West Virginia and Some of Southern Pennsylvania.

The service area for this Plan includes the following areas:

Baltimore City

Maryland Counties

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

Pennsylvania-Zip Codes Listed

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

West Virginia-Zip Codes Listed

25401	25427
25419	25443

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care or point-of-service benefits. We will not pay for any other health care services.

Section 3. How To Get Benefits *continued*

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. For anyone away for at least 90 days, the Plan offers Guest Membership at an affiliated HMO near your travel destination. Guest Membership allows you and your family to enjoy the full range of benefits offered by the Host HMO. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

How much do I pay for services?

You must share the cost of some services. This is called either a copayment (a set dollar amount) or coinsurance (a set percentage of charges). Please remember you must pay this amount when you receive services.

Your out-of-pocket expenses for in-network care are limited to the stated copayments which are required for a few benefits. However, when using the New Choice self referral program, after you pay $2,000 in coinsurance for one family member, or $4,000 for two or more family members, you do not have to make any further payments for certain services for the rest of the year. This is called a catastrophic limit. However, copayments or coinsurance for your prescription drugs, dental services, and coinsurance amounts for failure to obtain pre-authorization do not count toward these limits and you must continue to make these payments.

Be sure to keep accurate records of your copayments and coinsurance, since you are responsible for informing us when you reach the limits.

Do I have to submit claims?

You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us, or you use point-of-service benefits. 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.

Who provides my health care?

FreeState Health Plan, Inc. is a Health Maintenance Organization (HMO). An affiliate corporation of CareFirst BlueCross BlueShield, FreeState is a mixed mdoel HMO, contracting with medical centers and physicians to provide health care services to you.

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

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

What do I do if my primary care physician leaves the Plan?

Call us. We will help you select a new one.

What do I do if I need to go into the hospital?

Talk to your Plan physician. If you need to be hospitalized, your primary care physician or specialist will make the necessary hospital arrangements and supervise your care.

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

First, call our customer service department at 410/654-8670 or 800/445-6036. If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program and are switching to us, your former plan will pay for the hospital stay until:

Section 3. How To Get Benefits *continued*

- You are discharged, not merely moved to an alternative care center, or
- The day your benefits from your former plan run out, 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.

How do I get specialty care?

Your primary care physician will arrange your referral to a specialist except when you use the New Choice Point-of-Service benefits.

If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan. The physician may have to get an authorization, or approval, beforehand.

What do I do if I am seeing a specialist when I enroll?

Your primary care physician will decide what treatment you need. If they decide to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

What do I do if my specialist leaves the Plan?

Call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

But, 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. You may be able to continue seeing your provider for up to 90 days after we notify you 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.

How do you authorize medical services?

Your physician must get our approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care. Before giving approval, we consider if the service is medically necessary, and if it follows generally accepted medical practice.

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

To decide whether a service is experimental or investigational, the Plan considers the following questions:

1. Can this service be legally used in testing or other studies on human patients?
2. According to generally accepted medical standards, is this service recognized as safe and effective for the treatment of this condition?
3. When this service was rendered, was it approved by any governmental authority approval is required?
4. In the case of a drug, therapeutic regimen, or device: has it been approved for human use by the Federal Food and Drug Administration?

"Service" also means any treatment, procedure, drug, facility, equipment, device, or supply, or the usage of any of these things.

Section 4. What To Do If We Deny Your Claim Or Request For Service

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. Arrange for a health care provider to give you the service; 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 service?

Call us at 410/654-8670, 800/445-6036, 410/998-5768 TDD, 800/828-3196 TDD 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 claim, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you can call OPM's health benefits Contracts Division 3 at (202) 606-0755 between 8 a.m. and 5 p.m. Eastern Time. 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 of service. You may also ask OPM to review your claim if:

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

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

What do I send to OPM?

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

1. A statement about why you believe our decision is wrong, based on specific benefit provisions in this brochure;

2. Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;

Section 4. What To Do If We Deny Your Claim Or Request For Service *continued*

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, Contract Division III, P.O. Box 436, Washington, D.C. 20044.

What if OPM upholds the Plan's denial?

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

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

What laws apply if I file a lawsuit?

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

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

Your records and the Privacy Act

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

Section 5. Benefits

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; **you pay** a $10 office visit copay, but no additional copay for laboratory tests, x-rays and prenatal office visits. **You pay** nothing for well child care for children under 5 years of age. Within the service area, house calls will be provided if in the judgment of the Plan doctor such care is necessary and appropriate; **you pay** nothing for a doctor's house call; or home visits by nurses and health aides.

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

Section 5. Benefits *continued*

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

- Preventive care, including well-baby care and periodic check-ups (copay waived for well-child care for children up to age 5)
- Vision and hearing screening when performed by a Plan primary care doctor; complete hearing exam only when referred by a Plan primary care doctor
- Mammograms are covered as follows: for women age 35 through age 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 6 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. Copays are waived for maternity care. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child, when provided by a Plan doctor during the covered portion of the mother's hospital confinement for maternity, will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum). You pay nothing.
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints; breast prosthesis and surgical bras, as well as their replacement.
- Cornea, heart, heart-lung, kidney, liver, lung (single and double), pancreas, and pancreas-kidney transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, breast cancer, multiple myeloma, epithelial ovarian cancer, and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Transplants are covered when approved by the Plan Medical Director. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis; you pay nothing
- Chemotherapy and radiation therapy; you pay nothing
- Inhalation therapy
- Surgical treatment of morbid obesity
- Orthopedic devices, such as braces; foot orthotics, including replacement or adjustmen limited to that necessitated by the member's physical changes or growth

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

Section 5. Benefits *continued*

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

Limited benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion, and any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome, except as defined on pages 17-19.

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

A patient and her attending physician may decide whether to have breast reconstruction surgery following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient basis for up to two months per condition if significant improvement can be expected within two months; **you pay** nothing per session. Short-term rehabilitative therapy is provided on an outpatient basis; a combined benefit maximum for physical and occupational therapy is 90 visits per condition, per contract year; **you pay** $10 per visit. Speech therapy is covered for 90 visits, per condition, per contract year; **you pay** $10 per visit. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. Plan benefits are only available to the extent that the plan provider determines they can be expected to result in the improvement of a member's condition.

Diagnosis and treatment of infertility is covered. **You pay** $10 per office visit. The following type of artificial insemination is covered: Intracervical insemination (ICI); **you pay** a $10 copay per visit. Cost of donor sperm is not covered. Fertility drugs are not covered. Other assisted reproductive technology (ART) procedures such as in vitro fertilization, embryo transfer and intrauterine insemination (IUI) are not covered.

General anesthesia and associated hospital ambulatory facility charges in conjunction with dental care provided to a member, if the member is:

1. seven years of age or younger or is developmentally disabled;
2. an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the member, and
3. an individual for whom a superior result can be expected from dental care provided under general anesthesia.

Section 5. Benefits *continued*

Or if the member is:

1. an extremely uncooperative, fearful, or uncommunicative child who is 17 years of age or younger with dental needs of such magnitude that treatment should not be delayed or deferred; and
2. an individual for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.

Plan benefits provided by these services are subject to applicable copayments. Please contact the Plan for additional information regarding these copayments.

Clinical Trials - Plan benefits include coverage for patient costs related to a Clinical Trial, as a result of treatment provided for a life-threatening condition; or prevention, early detection, and treatment studies on cancer. These Plans benefits are provided only if:

1. The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV Clinical Trial for cancer; or
2. the treatment is being provided in a Phase II, Phase III, or Phase IV Clinical Trial for any other life threatening condition; and
3. the treatment is being provided in a Clinical Trial approved by: one of the National Institutes of Health, an NIH Cooperative Group or NIH Center, the FDA in the form of an investigational new drug application, the federal Department of Veterans Affairs,or an institutional review board of an institution in the State of Maryland that has a multiple project assurance contract approved by the Office of Protection From Research Risks of the NIH; and
4. There is no clearly superior, nonivestigational treatment alternative.

What is not co vered

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

Hospital/Extended Care Benefits

What is co vered

Hospital car e

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

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care

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

Section 5. Benefits *continued*

- Specialized care units, such as intensive care or cardiac care units
- Blood and blood derivatives

Extended care

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

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

Hospice care

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

Ambulance service

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

Limited benefits

Inpatient dental procedures

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

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 15 for nonmedical substance abuse benefits.

What is not covered

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

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

Emergency Benefits

What is a medical emergency?

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

Section 5. Benefits *continued*

Emergencies within the service area

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

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

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

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

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

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

Emergencies outside the service area

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

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

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

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

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

What is covered

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

What is not covered

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

Section 5. Benefits *continued*

Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card. Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 8.

Mental Conditions/ Substance Abuse Benefits

Treatment for mental health conditions and substance abuse may be obtained by calling Magellan Behavioral Health [formerly known as Green Spring Health Management Services] (or other vendor determined by the Plan); call 800/245-7013.

What is covered

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

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

Outpatient Care

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

Inpatient Care

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

Partial Hospitalization

Up to 60 days of partial hospitalization each calendar year; **you pay** a $10 copay per day - all charges thereafter.

Medication Management

Unlimited visits to a Plan doctor each calendar year; **you pay** a $10 copay per visit

What is not covered

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

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

Section 5. Benefits *continued*

Prescription Drug Benefits

What is co vered

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 34-day supply; **you pay** a $10 copay per generic prescription unit or refill and a $20 copay per name brand prescription unit or refill.

MAIL ORDER: Prescription drugs prescribed by a Plan or referral doctor may be purchased via mail order. The supplies of drugs dispensed and the copays charged are the same as when purchased at a Plan pharmacy. Call the Plan for details on ordering by mail.

GENERIC DRUGS: Substitution of generic equivalents for name brand drugs will be made by Plan pharmacies, except when there is no generic equivalent of a name brand drug or when an equivalent is available but a Plan doctor specifies only a name brand is to be used. Please note: If a generic is available and the prescribing doctor does not require the brand name drug, but you get the brand name drug, you pay the brand copay plus the difference in cost between the generic and brand prescription. If a generic is not available or the prescribing doctor requires the brand name drug, you pay only the brand copay.

MAINTENANCE DRUGS: Certain drugs are indentified as maintenance drugs on the Plan's Maintenance List. These drugs will be covered for a 90-day supply. You pay one prescription copayment of $10 for generic drugs and $20 for name brand drugs. Once again, you pay the difference in cost between the generic and brand prescription as stated above in the Generic Drugs paragraph.

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

Covered medications and accessories include:

- Drugs for which a prescription is required by law
- Dental prescriptions when written by a Plan dentist
- Oral and injectable contraceptive drugs; contraceptive diaphragms and devices. One copay applies to each month's supply of oral contraceptive drugs.
- Implanted contraceptive drugs, such as Norplant
- Insulin
- Insulin syringes and needles
- Disposable needles and syringes needed for injecting covered prescribed medication
- Diabetic supplies including acetone test, alcohol swabs, blood glucose control regents, blood glucose test kit, glucose monitoring test supplies, insulin injection device, lancets, swabs and test strips; you pay nothing
- Smoking cessation drugs and medication

Intravenous fluids and medications for home use are covered under Medical and Surgical Benefits

Limited Benefits

Drugs to treat sexual dysfunction are subject to dosage limitations. Contact the Plan for the dosage limitations.

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

Section 5. Benefits *continued*

What is not co vered

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

Other Benefits

Dental car e

What is co vered

United Concordia, or other dental vendor as determined by the Plan, is under contract with the Plan to provide dental benefits to Plan members. The following list summarizes the dental services provided by participating United Concordia dentists and indicates copayments where they apply. This Plan covers other dental services at varying copayment levels that are not specifically listed below. For further information regarding these services and applicable copayment levels, please call United Concordia at 800/822-3368. All dental services must be provided by participating United Concordia dentists.

Schedule of Benefits

Code #	Description of Services	Copay
	Clinical Oral Examinations	
00120	Periodic Oral Evaluation	$5
00140	Limited Oral Evaluation - Problem Focused	$5
00150	Comprehensive Oral Evaluation	$6
	Radiographs	
00210	Intraoral - Complete Series (incl. Bitewings)	$11
00272	Bitewings - 2 Films	$5
00330	Panoramic X-Rays	$11
	Dental Prophylaxis	
01110	Prophylaxis (Cleaning) - Adult (two per year)	$8
01120	Prophylaxis (Cleaning) - Child (two per year)	$6
	Topical Fluoride Treatment	
01203	Topical App. Of Fluoride Tx - Child (exclude prophy)	$3
01204	Topical App. Of Fluoride Tx - Adult (exclude prophy)	$3
01351	Sealant - Per Tooth	$3
	Amalgam Restorations (Including Local Anesthesia & Polishing)	
02110	Amalgam - one surface, primary	$27
02120	Amalgam - two surfaces, primary	$36
02130	Amalgam - three surfaces, primary	$49
02140	Amalgam - one surface, permanent	$27
02150	Amalgam - two surfaces, permanent	$36
02160	Amalgam - three surfaces, permanent	$49

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

Section 5. Benefits *continued*

Resin Restoration (Including Local Anesthesia)		
02330	Resin - one surface, anterior	$31
02331	Resin - two surfaces, anterior	$44
02332	Resin - three surfaces, anterior	$58
Complete Dentures (Including Routine Post-Del Care)		
05110	Complete maxillary denture	$399
05120	Complete mandibular denture	$399
05130	Immediate maxillary denture	$422
05140	Immediate mandibular denture	$422
Partial Denture (Including Routine Post-Del Care)		
05213	Max part dent resin base (incl. any conv. clasp/rests/teeth)	$482
05214	Mand part dent resin base (incl. any conv. clasps/rests/teeth)	$482
Adjustments to Removable Prosthesis		
05410	Adjust complete denture - maxillary	$14
05411	Adjust complete denture - mandibular	$15
05421	Adjust partial denture - maxillary	$18
05422	Adjust partial denture - mandibular	$18
Repairs to Partial Dentures		
05510	Repair broken complete denture base	$60
Extractions (Including Local Anesthesia and Routine Postoperative Care)		
07110	Single tooth	$ 31
07210	Surgical removal of erupted tooth requiring elevation of mucoperisteal flap	$ 44
07220	Removal of impacted tooth - soft tissue	$ 79
07230	Removal of impacted tooth - partially bony	$ 95
07240	Removal of impacted tooth - completely	$140
Orthodontics		
08070	Comprehensive - transitional	$2,025
08080	Comprehensive - adolescent	$2,025
08090	Comprehensive - adult	$2,025

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

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

Questions regarding plan benefits and features should be directed to United Concordia, 1-800-822-3368.

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

Section 5. Benefits *continued*

Accidental injury benefit

Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth are covered only when; the initiation of services is within 60 days of the accidental injury. Plan benefits for follow up care are limited to care rendered within one year of the date of the accidental injury. The need for these services must result from an accidental injury, and must be authorized by your primary care doctor. **You pay** $10 per visit.

When general anesthesia is necessary, the general anesthesia is covered under medical benefits and the dental procedures are approved by the Plan's dental vendor.

What is not covered

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

Vision care

What is covered

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

- Routine annual eye refraction, including written lens prescription for eyeglasses. **You pay** $10 per visit when the examination for annual eye refraction is provided by a MEC Health Care participating provider.
- Per 24 month period, at a MEC Health Care participating provider, one pair of prescription lenses (standard single vision, bifocal or trifocal) and frames will be covered when selected from the designated Frame Display. **You pay** nothing for standard single vision or bifocal, and $45 copay for trifocal (additional copays exist for lens enhancements). If lenses and frames are not selected from the designated Frame Display, you will have a $40 credit toward the frames you choose, and the standard single vision or bifocal lenses are still free; trifocals have a $45 copay (additional copays exist for lens enhancements). If you choose contact lenses instead of glasses, you can receive a pair of replacement standard soft daily wear contact lenses at no charge if you are a current contact lens wearer, ($50 copay if you are a new contact lens wearer). Contact lenses other than standard soft daily wear are available for additional copays which vary depending on whether you are or are not a current contact lens wearer. Please note: There is no out-of-network benefit for routine vision correction frames and lenses.

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

Point of Service Benefits

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

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

Section 5. Benefits *continued*

Deductible

For eligible self-referral services, you pay a $200 calendar year deductible for an individual, and $400 for a family, before the Plan pays any benefits.

Coinsurance

When the calendar year deductible has been met, the Plan pays 80% of the allowable benefit; you pay 20% of the allowed benefit. If the actual charge for a covered service is more than the allowed benefit, you must also pay the difference. Expenses incurred in the last month of the calendar year, which are used to satisfy the deductible, will apply to the deductible of the following calendar year.

Pre-authorization

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

Out-of-Pocket maximum

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

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

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

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

Medical and surgical benefits

What is eligible f or self-referral?

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

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

Section 5. Benefits *continued*

What is not eligible for self-referral

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

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

Hospital/extended care benefits

What is eligible for self-referral

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

- Inpatient hospitalization
- Skilled nursing facility
- Hospice care

Mental conditions/substance abuse benefits

What is eligible for Point of Service benefits

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

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

Emergency care

What is eligible for self-referral

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

Other covered benefits

What is eligible for self-referral

Prescriptions written as a result of a self-referral to a doctor are eligible for a $10 generic copayment and $20 brand copayment for a 34-day supply as long as they are filled at a Plan participating pharmacy. Please note: At a Plan participating pharmacy, if a brand name prescription is selected over a generic and the prescribing doctor does not require the brand name drug, you pay the brand copayment plus the difference in cost between the generic and brand prescription. If a non-participating pharmacy is used, you pay 20% of the allowed benefit after deductible.

How to file claims

Call the Client Services Department at 410/654-8670 or 800/445-6036 for claim forms and submit your claims to:

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

Section 5. Benefits *continued*

Non-FEHB Benefits Available to Plan Members

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

Expanded dental benefits

Freestanding non-group dental coverage-Just Dental High Option. FreeState Health Plan offers a freestanding non-group dental plan called Just Dental High Option. This dental plan is administered by United Concordia. You must enroll in Just Dental High Option during the same time that the FEHB Open Season is going on.

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

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

For more information, please call Just Dental (United Concordia) at 800/822-3368. Upon request, we will promptly send to you a pamphlet including specific enrollment procedures, dental services and fees, participating providers and an application form.

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

The 2000 Annual Premiums for Just Dental High Option are:

Individual:	$160.00
Parent/Child:	$239.00
Husband/Wife:	$277.00
Family:	$402.00

Expanded vision care

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

Medicare Prepaid Plan

Medicare prepaid plan enrollment - This Plan offers Medicare recipients the opportunity to enroll in a Plan through Medicare. As indicated on page 23, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at (410) 356-8123 or (800) 275-3802 for information on the Medicare prepaid Plan and the cost of that enrollment.

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

These non-FEHBP benefits are not part of the FEHBP contract.

Section 6. 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 your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness or condition.

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;
- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits) or eligible self-referred services (see Point of Service benefits);
- Experimental or investigational procedures, treatments, drugs or devices;
- Procedures, services, drugs and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Procedures, services, drugs and supplies related to sex transformations;
- Services or supplies you receive from a provider or facility barred from the FEHB Program; and
- Expenses you incurred while you were not enrolled in this Plan.

Section 7. 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 request it from SSA at 1-800/638-6833. For information on the Medicare+Choice plan offered by this Plan, see page 22.

Section 7. Limitations – Rules That Affect Your Benefits *continued*

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 what the reasonable charge for the benefit should be. 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. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

Circumstances beyond our control

Under certain extraordinary circumstances, we may have to delay your services or be unable to provide them. In that case, we will make all reasonable efforts to provide you with necessary care.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. We will cover the cost of treatment that exceeds the amount you received in the settlement. If you do not seek damages, you must agree to let us try. This is called subrogation. If you need more information, contact us for our 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.

Workers' compensation

We do not cover services that:

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

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

Medicaid

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

Other Government Agencies

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

Section 8. FEHB FACTS

You have a right to information about your HMO.

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 410/654-8670, 800/445-6036, 410/998-5768 TDD, 800/828-3196 TDD, or write to CareFirst BlueCross BlueShield/FreeState Health Plan, 10455 Mill Run Circle, 01-780, Owings Mills, MD 21117. You may also contact us by fax at 410/998-5809, or visit our website at 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 my family and me?

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 is incapable of self-support, which is also authorized by your employing or retirement office.

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. No new enrollment form is necessary.

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

Information for new members

Identification cards

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

What if I paid a deductible under my old plan?

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

Pre-existing conditions

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

When you lose benefits

What happens if my enrollment in this Plan ends?

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

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

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

What is former spouse coverage?

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

What is TCC?

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

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

Key points about TCC:

- You can pick a new plan;
- If you leave Federal service, you can receive TCC for up to 18 months after you separate;

Section 8. FEHB FACTS *continued*

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

How do I enroll in TCC?

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

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

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

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

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

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

How can I convert to individual coverage?

You may convert to an individual policy if:

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

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

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

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

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

Section 8. FEHB FACTS *continued*

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

Department of Defense/FEHB Demonstration Project

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

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

Who is Eligible?

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

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

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

Where are the demonstration areas?

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

When Can I Join?

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

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

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

Department of Defense/FEHB Demonstration Project *continued*

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

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

See Section 8, FEHB Facts, for information about TCC. Under this Demonstration Project the only individual eligible for TCC is one who ceases to be eligible as a "member of family" under your self and family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremarried former spouse under title 10, United States Code. For these individuals, TCC begins the day after their enrollment in the DoD/FEHBP Demonstration Project ends. TCC enrollment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHBP Demonstration Project.

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

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

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

Inspector General Advisory: Stop Health Care Fraud!

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 410/654-8670 or 800-445-6036 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 FreeState Health Plan, Inc. - 2000

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, AND SERVICES AVAILABLE AS POS BENEFITS, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.

	Benefits	Plan pays/provides	Page
Inpatient care	Hospital	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. You pay nothing	12-13
	Extended care	All necessary services, up to 100 days per calendar year. You pay nothing	13
	Mental conditions/ Substance abuse	Diagnosis and treatment of acute psychiatric conditions for up to 365 days of inpatient care per year. You pay nothing	15
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. You pay a $10 per office visit; nothing per house call by a doctor. You pay nothing for prenatal care and well child care for children under age 5	9-11
	Home health care	All necessary visits by nurses and health aides. You pay nothing	11
	Mental conditions/ Subtance Abuse	Unlimited outpatient visits per year. You pay a $15 copay per visits 1-5; a $25 copay per visit for visits 6 - 30; and a $35 copay per visit thereafter for the remainder of the year	15
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. You pay a $25 copay to the hospital or urgent care center for each emergency room visit and any charges for services that are not covered benefits of this Plan	13-14
Prescription drugs		Drugs prescribed by a Plan doctor or Plan dentist and obtained at a Plan pharmacy. You pay a $10 generic copay and $20 brand name copay per prescription unit or refill	16-17
Dental care		Accidental injury benefit; you pay a $10 copay per visit. Preventive dental care; you pay variable copays for most services	17-19
Vision care		One refraction annually. You pay a $10 copay per visit	19
Point of Service		Services of out-of-network doctors and hospitals. Not all benefits are covered. You pay deductibles and coinsurance and a maximum benefit applies. After your coinsurance and deductible expenses reach a maximum of $2,000 per Self or $4,000 per Self and Family enrollment per calendar year, covered benefits will be provided at 100% of the allowed benefit for the remainder of the calendar year. Coinsurance amounts for failure to obtain pre-authorization do not contribute toward the out-of-pocket maximum	19
Out-of-pocket limit		Your out-of-pocket expenses covered under this Plan and authorized by Plan providers are limited to the stated copayments which are required for a few benefits	6

2000 Rate Information for
FreeState Health Plan

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

Postal rates apply to most career U.S. Postal Service employees. 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	**LD1**	**$78.83**	**$46.07**	**$170.80**	**$99.82**	**$93.06**	**$31.84**	**$93.26**	**$31.64**
Self and Family	**LD2**	**$175.97**	**$108.82**	**$381.27**	**$235.78**	**$207.74**	**$77.05**	**$201 .02**	**$83.77**