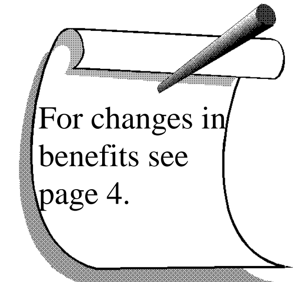
Blue Shield of California 2000
Access+

A Health Maintenance Organization



Serving: Most of California

Enrollment Code:

SJ1 Self Only

SJ2 Self and Family

Enrollment in this Plan is limited; see pages 4 and 5 for requirements.

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

and

this Plan's website at http://www.blueshieldca.com

Authorized for distribution by the:

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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

Section 3. How to get benefits ... 4-8

Section 4. What to do if we deny your claim or request for service ... 8-10

Section 5. Benefits ... 10-18

Section 6. General exclusions – Things we don't cover ... 20

Section 7. Limitations – Rules that affect your benefits ... 20-21

Section 8. FEHB facts ... 22-25

Department of Defense/FEHB Demonstration Project ... 25-26

Inspector General Advisory: Stop Healthcare Fraud! ... 26

Summary of benefits ... 27

Premiums ... 28

Introduction

Blue Shield of California
50 Beale Street
San Francisco, CA 94105-1808

This brochure describes the benefits you can receive from Blue Shield of California Access+ under its contract (CS2639) 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 page 4. Premiums are listed at the end of this brochure.

Plain language

The President and Vice President are making 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 Access+ 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 rewritten the Benefits section of this brochure. You will find new benefit language next year.

How to use this brochure

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 (HMOs).** 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 obtain 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, including an optional dental plan.

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 preventive care such as routine office visits, physical exams, well-baby care and immunizations, 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 you may have to submit claim forms. If you visit a Medical Eye Services provider for your annual eye refraction, you will be asked to complete a brief claim form.

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, 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 premiums as low as possible OPM has set a minimum copay of $10 for most 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 attach a separate, brief statement to it. If they do not provide you with 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 Blue Shield of California Access+ premium will increase by 11.2% for Self Only or for Self and Family.

The benefit for the diagnosis and treatment of infertility will not cover assisted reproductive technology (ART) procedures such as in vitro fertilization, gamete and zygote intrafallopian transfer and related services including medications, laboratory and radiology services. Artificial insemination is covered. At the physician's office or pharmacy, **you pay** 50% of allowable charges for covered injectable drugs. At Plan pharmacies, **you pay** a $6 copay for covered oral infertility drugs.

Prescription drug coverage will be provided with a $6 copay per prescription unit or refill for up to a 30-day supply. Previously, coverage was provided for a 34-day supply.

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:

What is this Plan's service area? *continued*

County Name	Excluded ZIP Codes
Alameda	None
Butte	None
Contra Costa	None
County Name	**Excluded ZIP Codes**
El Dorado	95613, 95619, 95623, 95633, 95636, 95643, 95651, 95656, 95667, 95672, 95682, 95684, 95709, 95720, 95721, 95726, 95735, and 96150 to 96158
Fresno	None
Kern	93501, 93502, 93504, 93505, 93516, 93519, 93527, 93528, 93554 to 93556, 93560 and 93596
Kings	None
Los Angeles	90704
Madera	None
Marin	None
Merced	None
Napa	None
Nevada	95724, 95728, 96111 and 96160 to 96162
Orange	None
Placer	95701, 95714, 95715, 95717, 96140 to 96143, 96145, 96146 and 96148
Riverside	92225-26
Sacramento	None
San Bernardino	92242, 92280, 92304, 92319, 92338 and 92363
San Diego	91905, 91906, 91934, 91948, 91963, 91980, 91987, 91990 to 91995, 92004 and 92086
San Francisco	None
San Joaquin	None
San Luis Obispo	None
San Mateo	None
Santa Barbara	None
Santa Clara	None
Santa Cruz	None
Shasta	None
Solano	None
Sonoma	None
Stanislaus	None
Tulare	None
Ventura	None
Yolo	None

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will normally pay only for emergency care. We will not pay for any other health care service, except those that are specifically addressed in the sixth paragraph on page 12 and on page 19 under the heading "Medical Care for Vacations, Business Travel and College Students."

If you or a covered family member move outside the 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 like ours that has agreements with affiliates in other states. See page 19 for details about our HMO-Blue-USA Away from Home coverage. 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 allowable charges). Please remember you must pay this amount when you receive services, except **you pay** nothing for preventive services like periodic physical exams, well-baby visits and maternity check-ups. See a complete list of these preventive services on pages 10 and 11.

After you pay $1,000 in copayments or coinsurance for a Self Only enrollment or $2,000 for a Self and Family enrollment, you do not have to make any further payments for most services for the rest of the year. This is called a catastrophic limit. However, copayments or coinsurance for: (1) your prescription drugs, (2) outpatient mental health and substance abuse services, (3) infertility services or (4) the Access+ self-referral specialty visit copayments do not count toward these limits and you must continue to make payments.

How much do I pay for services? *continued*

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. 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 you received the services. 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?

Access+ is a mixed model Individual Practice Association (IPA)/Medical Group HMO with an extensive network of providers conveniently located in the communities where you live and work. Access+ offers a Health Plan with a choice of 280 Plan hospitals, 160 other acute care hospitals, 9,800 primary care physicians, 17,000 specialists, and other health care professionals. Each family member has the freedom to choose a different physician. You or your dependent(s) may change primary care physicians by calling the Plan at 1-800-334-5847 or by submitting a Member Change Request Form to the Member Services Department. The change will be effective on the first day of the month after Blue Shield approves it. Once your primary care physician change is effective, all care must be provided or arranged by the new primary care physician, except for: (1) OB/GYN services provided by an obstetrician/gynecologist or family practice physician within the same IPA/Medical Group as the primary care physician or (2) Access+ specialist self-referral visits.

Changing your primary care physician during a course of treatment, during hospitalization or while pregnant may interrupt the quality and continuity of your care. For this reason, the effective date of your new primary care physician, when requested in the three situations listed above, will be the first of the month following discharge from the hospital, delivery of the baby or the date it is medically appropriate to transfer your care to your new primary care physician, as determined by the Plan. Exceptions must be approved by the regional Blue Shield Medical Director. For information about an exception to the above provisions, please contact Member Services.

You will have the opportunity through our Personal Health Management Program[sm] to be an active participant in your own health care with Access+ by calling 1-800-244-4755. We'll help you make a personal commitment to maintain, and, where possible, improve your health status. We believe that maintaining a healthy lifestyle and preventing illness are as important as caring for your needs when you are ill or injured.

Your Plan coverage includes worldwide emergency care. Members may also receive care for urgent services when traveling out-of-state through HMO-Blue-USA. Members call 1-800-4-HMO-USA to obtain information about the nearest participating provider. To arrange for urgent care while traveling out of the service area within California, members call their primary care physician or 1-800-334-5847.

As a not-for-profit partner in your health care, you'll receive the benefit of Blue Shield's 60-year commitment to service.

The most important decision that you will make is your selection of a primary care physician. It is through this physician that most all other health services are obtained. Your primary care physician is usually responsible for obtaining authorizations from the Plan before referring you to a specialist. You can self-refer to a participating physician in the same IPA/Medical Group as your primary care physician under the Access+ option and pay a $30 office copayment for this added freedom of choice (with the exception of mental health care, infertility, urgent care and allergy services). Services of other providers are covered only when there has been a referral by your primary care physician, with the exception of the Access + self-referral option and OB/GYN Services. Access+ self-referral and OB/GYN visits must be to a physician in the same IPA/Medi-

Who provides my health care?

continued

cal Group as your primary care physician to assure quality of care. Your primary care physician will also make arrangements for hospitalizations.

The Plan's provider directory lists primary care physicians (family and general practitioners, pediatricians, internists, and some OB/GYNs), with their locations and phone numbers, and whether or not the physician is accepting new patients. Directories are updated on a regular basis (but are subject to change without notice) and are available at the time of enrollment or upon request by calling the Member Services Department at 1-800-334-5847; you can find out if a physician participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. Important note: **When you enroll in this Plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any physician, hospital, or other provider, cannot be guaranteed.**

Should you decide to enroll, you will be asked to complete a primary care physician selection form and send it directly to the Plan, indicating the name(s) of the primary care physician(s) you select for you and each member of your family.

What to 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 will make the necessary arrangements and supervise your care.

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

First, call our customer service department at 1-800-334-5847. 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:

- You are discharged, not merely moved to an alternate 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 receive specialty care?

Your primary care physician will arrange your referral to a specialist. The exceptions to this are: (1) for true medical emergencies, (2) when another physician is on call for your physician, (3) when you self refer to an Access+ participating specialist (not applicable to mental health care, infertility, urgent care and allergy services) and (4) OB/GYN services provided by an obstetrician/gynecologist or family practice physician within the same IPA/Medical Group as your primary care physician. In all other instances, referral to a specialist is done at the primary care physician's discretion; if non-Plan specialists or consultants are required, the primary care physician will arrange appropriate referrals.

The following procedures apply to all members except those using the Access+ self-referral option. When you receive a referral from your primary care physician, you must return to the primary care physician after consultation. All follow-up care must be provided or authorized by the primary care physician. On referrals, the primary care physician will give specific instructions to the specialist as to what services are authorized. If additional services or visits are suggested by the specialist, you must first check with your primary care physician. Do not go to the specialist unless your primary care physician has arranged for an authorization for the referral in advance.

How do I receive specialty care? *continued*

If you need to see a specialist frequently because of chronic, complex or serious medical condition, your primary care physician will develop a treatment plan that allow you to see your specialist for a certain number of visits without referrals. Your primary care physician will use our criteria when creating your treatment plan.

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

Your primary care physician will usually decide what specialty treatment you need. However, members can self refer to specialists in the same IPA/Medical Group under the Access+ option.

If you are not using the self-referral option, and your primary care physician decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate in your new IPA/Medical Group, 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 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?

Access+ covers drugs, devices that are medically indicated and biological products no longer considered to be investigational by the Food and Drug Administration. Coverage for other procedures are reviewed by and decided by the Blue Shield of California Medical Policy Committee. The primary criteria are that the proposed new procedures are safe and effective.

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 1-800-334-5847 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 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 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 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 do not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What do I send to OPM?

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

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

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

Who can make the request?

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

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

What if OPM upholds the Plan's denial?

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

If you decide to sue, you must file 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 lawsuits, 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 physicians and other Plan providers. This includes all necessary office visits; **you pay** a $10 office visit copay for other than preventive and maternity services, but no additional copay for laboratory tests and X-rays. Within the Service Area, house calls will be provided if, in the judgment of the Plan physicians, such care is necessary and appropriate; **you pay** a $25 copay for a Plan physician's house call, $5 for home visits by nurses and health aides.

The following services are included:

- Preventive care, including well-baby care and periodic check-ups (**You pay** nothing)
- Mammograms are covered as follows: for women 35 through 39, one mammogram during these five years; for women 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the Plan physician as medically necessary to diagnose or treat your illness. (**You pay** nothing)
- Routine immunizations and boosters (**You pay** nothing)
- Hearing screening by the primary care physician for members under the age of 18 to determine the need for an audiogram or hearing correction (You **pay** nothing)
- Vision screening by the primary care physician for members under the age of 18 to determine the need for refraction or vision correction (**You pay** nothing)
- Consultations by specialists (**You pay** $10)
- Self referral to a participating specialist through the Access+ option (**You pay** $30 per visit)
- Diagnostic procedures, such as laboratory tests and X-rays (**You pay** nothing)

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN PHYSICIANS

Medical and Surgical Benefits *continued*

What is covered *continued*

- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan physician. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Inpatient stays will be extended if medically necessary. If the hospital stay is less than 48 hours after a regular delivery or 96 hours after a cesarean section delivery, a follow-up visit for the mother and newborn within 48 hours of discharge is covered when prescribed by the treating physician. The treating physician, in consultation with the mother, will determine whether this visit will occur at home, the contracted facility or the physician's office. Also included is the prenatal diagnosis of genetic disorders of the fetus in high-risk pregnancy cases. 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 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. (**You pay** nothing)
- Voluntary sterilization and family planning services (**You pay** $100 for tubal ligation; $75 for vasectomy; nothing for office visits)

- Diagnosis and treatment of diseases of the eye (**You pay** $10)

- Allergy testing and treatment (**You pay** $10 per visit). **You pay** nothing for injectables/serum unless they are made separately (e.g., customized antigens), in which case **you pay** a coinsurance of 50% of allowable charges

- The insertion of internal prosthetic devices, such as pacemakers and artificial joints (**You pay** $10)

- Cornea, kidney, heart, skin, lung, heart and lung in combination, kidney and pancreas in combination, liver transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions when authorized in writing by the Blue Shield Medical Director and performed at approved facilities: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Breast cancer, multiple myeloma and epithelial ovarian cancer are covered only when approved by the Plan's Medical Director and performed as part of a clinical trial conducted at a Cancer Research Facility that is funded by the National Cancer Institute. (**You pay** nothing) 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, remain in the hospital up to 48 hours after the procedure**. (You pay** nothing) Coverage includes all stages of reconstruction of the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. Treatment of physical complications of mastectomy, including lymphedemas, is also a covered benefit.

- Outpatient hospital services for treatment or surgery and necessary supplies (**You pay** $50 per treatment or surgery)

- Chemotherapy, radiation therapy, dialysis and inhalation therapy (**You pay** $10 per office visit or **you pay** nothing in a hospital setting)

- Surgical treatment of morbid obesity (**You pay** nothing as an inpatient)

Medical and Surgical Benefits *continued*

What is covered *continued*

- Orthopedic devices (and their repair) such as braces; functional foot orthoses (**You pay** 50% of allowable charges)

- Prosthetic services (and their repair) such as artificial limbs and contact lenses necessary to treat certain medical eye conditions. Contact the plan for details. Breast prostheses, including the surgical bra used for an external prosthesis, and necessary replacement prostheses and bras are covered benefits. (**You pay** 50 % of allowable charges)

- Durable medical equipment, such as wheelchairs and hospital beds (**You pay** 50% of allowable charges)

- Home health service of nurses and health aides, including intravenous fluids and medications, when prescribed by a Plan physician, who will periodically review the program for continuing appropriateness and need (**You pay** $5 per visit)

- All necessary medical or surgical care in a hospital or extended care facility from Plan physicians and other Plan providers**.** (**You pay** nothing)

- Urgent care services through HMO-Blue-USA when traveling out-of-state by calling 1-800-4-HMO-USA for a referral. When traveling within State but out of your Service Area, call your primary care physician or 1-800-334-5847. (**You pay** a $50 per visit copay)
- Injectable medications (Other than allergy and infertility injections, y**ou p**ay nothing)

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. Medically necessary non-surgical treatment (e.g., splint therapy and physical therapy) of Temporomandibular Joint Syndrome (TMJ) is covered. Surgical and arthroscopic treatment of TMJ is covered if prior history shows conservative medical treatment has failed. (**You pay** nothing as an inpatient) All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

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. (**You pay** nothing as an inpatient)

Cryosurgery for localized prostate cancer is considered to be an appropriate treatment and is a covered benefit when medically necessary. **You pay** $50 per treatment or surgery for outpatient hospital services or nothing in the hospital. This surgical procedure is still considered to be experimental and investigational for salvage therapy and is not covered for local failures after radical prostatectomy, external beam irradiation and brachytherapy.

Rehabilitative therapy is covered for physical, speech, occupational and inhalation; **you pay** a $10 copay per outpatient session. This is a covered benefit when determined by the Plan to be medically necessary and it is demonstrated that the member's condition will significantly improve as a result of these services. 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.

Limited benefits *continued*

Chiropractic services are covered up to 20 visits per calendar year. **You pay** a $10 copay per visit. Each member is allowed a pre-authorized appliance benefit of up to $50 per year. Examples of covered appliances are elbow supports, back supports (thoracic) and cervical collars. Unlimited chiropractic discounts are also available. See mylifepath features on page 19.

Diagnosis and treatment of infertility is covered. Artificial insemination is covered; **you pay** 50% of allowable charges for all services; Cost of donor sperm, eggs and frozen embryos and their collection and storage is not covered. Other assisted reproductive technology (ART) procedures that enable a woman with otherwise untreatable infertility to become pregnant through other artificial conception procedures such as in vitro fertilization and embryo transfer are not covered. At the physician's office or pharmacy, **you pay** 50% of allowable charges for covered injectable drugs. At Plan pharmacies, **you pay** a $6 copay for covered oral infertility drugs.

Cardiac rehabilitation following a heart transplant, bypass surgery, or a myocardial infarction is provided at a Plan facility, if medically necessary with the appropriate treatment plan; **you pay** $10 per visit

What is not covered

- Physical examinations 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 and examination for hearing aids (exams only covered for children under 18)
- Transplants not listed as covered
- Assisted reproductive technology (ART) procedures
- Organ donor costs and travel expenses
- Routine foot care
- Wigs
- Speech, language or vision assistance devices
- Services for or related to acupuncture (see page 19 for unlimited acupuncture discounts)
- Surgery to correct refractive error such as radial keratotomy and refractive keratoplasty

Hospital/Extended Care Benefits

What is covered

Hospital care

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

- Semiprivate room accommodations; when a Plan physician determines it is medically necessary, the physician may prescribe private accommodations or private duty nursing care
- Specialized care units, such as intensive care or cardiac care units

What is covered *continued*

Extended care

The Plan provides a comprehensive range of benefits 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 physician and approved by the Plan. Admissions to a subacute care setting require prior Plan approval and are limited to 100 days each calendar year. **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 physician.

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or a hospice facility. Care received in the home is limited to 100 visits per year and is subject to a $10 copay for physicians and a $5 copay per visit for other health care providers. Care received in a hospice facility provides for 100 days of service, applied against the Extended Day Care Limits, without copayment. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan physician 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 physician.

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan physician 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 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 physician determines that outpatient management is not medically appropriate. See pages 16 and 17 for more about 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 PHYSICIANS

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 and 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 sudden inability to breathe. There are many other acute conditions that you and the Plan may determine are medical emergencies – what they all have in common is the need for quick action.

Emergency Benefits *continued*

Emergencies within the service area

If you are in an emergency situation, please call your primary care physician. In extreme emergencies, if you are unable to contact your physician, 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 a Plan physician believes 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.

Any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Plan pays...

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

You pay...

$50 per hospital emergency room visit or urgent care center visit for emergency services that 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 physician believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Plan pays...

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

You pay...

$50 per emergency room visit or per urgent care center visit for emergency services that 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 physician's office or an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including physician's services
- Ambulance service approved by the Plan

What is not covered

- Elective care or nonemergency care
- Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area

Emergency 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. Mail this information to Blue Shield of California HMO Member Services, P.O. Box 272550, Chico, CA 95927. 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 pages 8 and 9.

Mental Conditions/Substance Abuse Benefits

Mental conditions

What is covered

To the extent shown below, the Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including treatment of mental illness or disorders:

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

Outpatient care

Up to 40 outpatient visits to Plan physicians, consultants, or other psychiatric personnel each calendar year; **you pay** a $25 copay for each covered visit 1-20 and 50% of allowable charges for visits 21-40 -- all charges thereafter.

Inpatient care

Up to 30 days of hospitalization each calendar year, **you pay** $50 per day for first 30 days or $25 per day of day-care for up to 60 days, or a combination of inpatient and day-care where 2 day-care days count as 1 inpatient day up to a maximum of 30 equivalent inpatient days. **You pay** all charges thereafter.

Psychiatric day-care is care in which patients participate during the day, returning to their homes or other community placement during the evening or night.

What is not covered

- Care for psychiatric conditions that in the professional judgment of Plan physicians are not subject to significant improvement through relatively short-term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan physician to be necessary and appropriate
- Psychological testing that is not medically necessary to determine the appropriate treatment of a short-term psychiatric condition
- Self referrals to psychiatrists or other mental health care providers under the Access+ self-referral option

Substance abuse

What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition. Services for the psychiatric aspects are provided in conjunction with the mental conditions benefit shown above. Outpatient visits to Plan providers

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN PHYSICIANS

Mental Conditions/Substance Abuse Benefits *continued*

Substance abuse

What is covered *continued*

for treatment are covered, as well as inpatient services necessary for diagnosis and treatment. The mental conditions benefits visit limitation and copays apply to any covered substance abuse care.

What is not covered

- Treatment that is not authorized by a Plan physician.
- Self referrals to any mental health provider through the Access+ self-referral option

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan or referral physician and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply. Coverage is based on the use of the Prescription Drug Formulary, a copy of which is available to members. Non-formulary drugs will be covered when prescribed by a physician and approved by the Plan. Members' physicians are responsible for obtaining authorizations from the Plan for all non-formulary drugs. Members should not become directly involved with the Plan for this preauthorization process. Instead, their physicians should document medical necessity for non-formulary drugs during regular business hours by calling the Plan's toll-free Pharmacy Services Prior Authorization hotline, 1-800-535-9481. If all necessary documentation is available from your physician, prior authorization approval or denial will be provided to your physician within two working days of the request.

Medications are selected for inclusion in Blue Shield's Outpatient Prescription Drug Formulary based on safety, efficacy, and FDA bioequivalency data. The Blue Shield Pharmacy and Therapeutics Committee reviews new drugs and clinical data four times a year.

Members may call Blue Shield Member Services at 1-800-334-5847 to find out if a specific drug is included in the Formulary. New members receive a printed copy of the Formulary with their welcome kits. Formulary information is also available on Blue Shield's web site at http://www.blueshieldca.com.

In lieu of brand name drugs, generic drugs will be dispensed when substitution is permissible by the physician. If you request a brand name drug when a generic drug is available, **you pay** the difference between the cost of the brand name drug and its equivalent generic drug, plus the copayment. **You pay** a $6 copay per prescription at Plan pharmacies. To obtain prescription drugs, present your Access+ identification card at a participating pharmacy. For out-of-state emergencies, **you pay** a $6 copay.

Mail Order Drug Program—Prescriptions are also available by mail for up to a 90-day supply. Generic drugs will be dispensed in lieu of name brand drugs when substitution is permissible by the physician. **You pay** a $6 copay per prescription unit or refill. If you request a brand name drug when a generic drug is available, **you pay** the difference between the cost of the brand name drug and its equivalent generic drug, plus the copayment**.** Call Member Services at 1-800-334-5847 to receive a packet for ordering prescriptions through the mail.
Covered medications include:

- Medically necessary drugs for which a prescription is required by law
- Oral contraceptive drugs—up to a three-cycle supply may be obtained for a single copay charge
- Diaphragms when obtained at a Plan pharmacy
- Insulin, with a copay for each 30 or 90-day supply
- Disposable needles and syringes needed for injecting covered medication

What is covered *continued*

- Diabetic supplies limited to insulin syringes, needles and glucose testing tablets and strips
- Intravenous fluids and medications for home use and some injectable drugs, such as Depo Provera, are covered under Medical and Surgical Benefits. Diaphragms are covered if your physician writes a prescription for the device.
- Drugs for sexual dysfunction or sexual inadequacies will be covered when the dysfunction is caused by medically documented organic disease. Prior Plan approval is required and the maximum dosage dispensed will be limited by the protocols established by the Plan. Certain drugs for these conditions are not available through the Mail Order option.

What is not covered

- 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
- Vitamins and nutritional substances that can be purchased without a prescription
- Medical supplies such as dressings and antiseptics
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- IUDs and Norplant dispensed by your physician are covered under Medical and Surgical Benefits and not the Prescription Drug Benefit.
- Implanted time-release medications
- Drugs for weight loss
- Smoking cessation drugs

Other Benefits

Dental care

Accidental injury benefit

Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth are covered. The need for these services must result from an accidental injury commencing within 90 days of the accidental injury or within 90 days of medical appropriateness of treatment and within one year of the injury. **You pay** a $10 copay per visit.

See page 19 for details about a comprehensive, low cost optional Blue Shield dental plan.

Vision care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of disease of the eye, annual eye refractions (to provide a written lens prescription) may be obtained from Medical Eye Services (MES) providers; **you pay** a $10 copayment. MES directories can be ordered by calling 1-800-334-5847.

What is not covered

- Corrective lenses or frames
- Eye exercises

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN PHYSICIANS

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with FEHB, but are made available to all enrollees and family members who are 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 or out-of-pocket maximums. These benefits are not subject to the FEHB disputed claims procedure.

Blue Shield Dental Option -- Comprehensive and Affordable

CAUTION: When shopping for a dental plan, please carefully compare: (1) copayments, (2) waiting periods and (3) dues.

Enroll in Access+ and pay dues directly to Blue Shield to join this no waiting period dental plan. Dues can be paid monthly or quarterly (Dues are also shown on a biweekly basis for your convenience in comparing costs.). Call 1-888-271-4929 for a list of dentists, a summary of benefits and an enrollment form.

	Biweekly Dues	Monthly Dues	Quarterly Dues
Self only	$6.95	$15.05	$45.15
Two party	$13.64	$29.56	$88.68
Family	$20.08	$43.51	$130.53

Care must be received from or arranged by a Blue Shield Dental Option provider. Below are sample copayments:

Office visits	$5	Fillings (per surface)	$15	Root canal (one canal)	$125
Bitewing X-rays	$0	Metal crowns (each)	$250	Full upper or lower denture	$250
Prophylaxis	$0	Single, routine extraction	$20	Orthodontics (children only)	$1,800

Receive Discounts from Vision One Eyecare Program on Frames and Lenses

Federal employees with Access+ coverage can enjoy savings of up to 66.7% on frames and lenses through our Vision One Eyecare Program at almost 250 Cole Vision California locations. Cole Vision services are available in the optical departments of many Sears, Montgomery Ward and JCPenney stores, at Pearle Vision locations and at offices of participating private practice doctors. There is no added premium for this money-saving feature. Simply present your Access+ identification card when you pay for your eyewear and the discounts are automatic.

For coverage of eye refractions see page 18.

Significant Discounts through the mylifepath[sm] Program - Acupuncture, Massage & More

Access+ offers you participation in mylifepath, which entitles you to significant discounts on health and wellness services. When you see a practitioner in the mylifepath network, you'll experience substantial savings on acupuncture, chiropractic, massage, fitness centers, health spas, and wellness programs. You will be responsible for all charges remaining after the discounts. For more details on all features, please call 1-888-999-9452. Also visit our website, mylifepath.com for health information and news about other value-added features.

Medical Care for Vacations, Business Travel and College Students

HMO-Blue-USA covers you and eligible family members in hundreds of cities in 43 states and the District of Columbia while you're on vacation, on business travel or away from home at college. There are no additional premiums for this Away from Home Care. You pay office copayments, which vary from state to state ($5 to $25) for guest visits and $50 for urgent care visits. Call 1-800-334-5847 for details.

Blue Shield 65 Plus, A Medicare+Choice Prepaid Plan

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 20, 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 if 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 have to pay for hospital coverage in certain instances 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 1-888-713-0000 for information on the Medicare prepaid plan and the cost of that enrollment. Blue Shield 65 Plus is now available in Alameda, Contra Costa, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara and Ventura counties.

Benefits on this page are not part of the FEHB 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 physician 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);
- 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;
- Expenses you incurred while you were not enrolled in this Plan;
- Procedures, services, drugs and supplies related to sexual dysfunction or sexual inadequacies (including penile prostheses) except as provided for medically documented treatment of organically based conditions;
- Services performed by a close relative (the spouse, child, brother, sister, or parent of a subscriber or dependent) or a person who ordinarily resides in the member's home; and
- Hospitalization or confinement in a health facility for treatment of eating disorders such as bulimia, anorexia, etc., except to treat separately identified psychiatric or medical conditions arising from such disorders when an acute level of care is medically necessary.

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 Access+, see the bottom of page 19.

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 the 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. 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 at 530-666-2238 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:

- 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 determines 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 for which a local, State, or Federal Government agency directly or indirectly pays.

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 at www.opm.gov lists the specific types of information that we must make available to you.

If you want specific information about us, call 1-800-334-5847, or write to Members Services Department, Blue Shield of California Access+, P.O. Box 272550. Chico, CA 95927. You may also contact us by fax at 916-351-7790 or visit our website at www.blueshieldca.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 Benefit Plans*, brochures for other plans and other materials you need to make an informed decisions about:

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

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

When are my benefits and premiums effective?

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

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

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

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

Are my medical and claims record 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;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal activities;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that do 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.

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 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 him or her 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 cancelled 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 your 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 were enrolled with us. You can use this certificate when getting health insurance or other health care coverage. You must arrange for the other coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on the information in the certificate.

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

Department of Defense/FEHB Demonstration Project

What is the Department of Defense (DoD) and FEHB Program 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 elect 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 outside of Open Season, contact the IPC to find out how to enroll and when your coverage will begin.

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

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

See Section 10, FEHB Facts, for information about TCC. Under this Demonstration Project the only individual eligible for TCC is one who ceases to be eligible as a "member of family" under your self and family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremmaried 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 1-800-334-5847 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 Blue Shield of California Access+ 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, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN PHYSICIANS.**

Benefits		Plan pays/provides	Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital physician 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	13
	Extended care	All necessary services, limited to 100 days each calendar year. **You pay** nothing	14
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care or 60 days of day care (or a combination as described) per year. **You pay** $50 per inpatient day and $25 per day-care day	16
	Substance abuse	Covered under Mental Conditions	16
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care. **You pay** a $10 copay per office visit; $30 per self-referred Access+ specialist office visit**;** $25 per house call by physician. Preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** nothing	10
	Home health care	All necessary visits by nurses, therapists and health aides. **You pay** $5 per visit	10
	Mental conditions	Up to 40 outpatient visits per year. **You pay** a $25 copay per visit for visits 1-20; 50% of charges for visits 21-40	16
	Substance abuse	Covered under Mental Conditions	16
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $50 copay to the hospital for each emergency room visit and any charges for services that are not covered benefits of this Plan	14
Prescription drugs		Drugs prescribed by a Plan physician and obtained at a Plan pharmacy or through the Plan's mail order program. **You pay** a $6 copay per prescription unit or refill	17
Dental care		Accidental injury benefit; **you pay** $10 per office visit	18
		Optional comprehensive dental plan; **you pay** total premium plus various copays	19
Vision care		One eye refraction annually. **You pay** a $10 copay	18
Out-of-pocket maximum		Copayments and percentages of allowable charges are required for a few benefits, however, after your out-of-pocket expenses reach a maximum of $1,000 per Self Only or $2,000 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum does not include charges for prescription drugs, outpatient mental health and substance abuse, infertility services, or the $30 copay for self-referral specialty visits	5

2000 Rate Information for Blue Shield of California Access+

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 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	**SJ1**	**$61.47**	**$20.49**	**$133.19**	**$44.39**	**$72.74**	**$9.22**	**$72.74**	**$9.22**
Self and Family	**SJ2**	**$152.50**	**$50.83**	**$330.41**	**$110.14**	**$180.46**	**$22.87**	**$180.46**	**$22.87**