# Blue Cross® and Blue Shield® Service Benefit Plan

**1997**

**A Managed Fee-for-Service Plan with a Preferred Provider Organization and a Point-of-Service Product Administered by the Blue Cross and Blue Shield Association**

**Who may enroll in this Plan:** All Federal employees and annuitants who are eligible to enroll in the FEHBP.

**Enrollment code for this Plan:**

**101 High Option Self Only**
**102 High Option Self and Family**
**104 Standard Option Self Only**
**105 Standard Option Self and Family**

Authorized for distribution by the:

Federal Employees Health Benefits Program

RI 71-5

# Blue Cross® and Blue Shield® Service Benefit Plan

The Blue Cross and Blue Shield Association (Carrier), on behalf of Blue Cross and Blue Shield Plans, has entered into Contract No. CS 1039 with the Office of Personnel Management (OPM) to provide a health benefits plan (Plan) authorized by the Federal Employees Health Benefits (FEHB) law. The Plan is underwritten by Participating Blue Cross and Blue Shield Plans which administer this Plan on behalf of the Carrier and are referred to as Local Plans in this brochure. The FEHB contract specifies the manner in which it may be modified or terminated.

This brochure is based on text incorporated into the contract between OPM and the Carrier as of January 1, 1997 and is intended to be a complete statement of benefits available to FEHB members. It describes the benefits, exclusions, limitations, and maximums of the Blue Cross and Blue Shield Service Benefit Plan for 1997 and until amended by future benefit negotiations between OPM and the Carrier. It also describes procedures for obtaining benefits. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control. Oral statements cannot modify the benefits described in this brochure.

An enrollee does not have a vested right to receive the benefits in this brochure in 1998 or later years, and does not have a right to benefits available prior to 1997 unless those benefits are contained in this brochure.

# Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD which may result in CRIMINAL PENALTIES.

Please review all medical bills, medical records, and claims statements carefully. If you find that a provider, such as a doctor, hospital, pharmacy, etc., charged your Plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider (doctor, hospital, etc.) and ask for an explanation—sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your Carrier at 1-800/FEP-8440 and explain the situation.
- If the matter is not resolved after speaking to your Carrier (and you still suspect fraud has been committed), call or write:

**THE HEALTH CARE FRAUD HOTLINE**
**202/418-3300**

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, DC 20415

The inappropriate use of membership identification cards, *e.g.,* to obtain benefits for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

# Using This Brochure

The **Table of Contents** will help you find the information you need to make the best use of your benefits. To get the best value for your money, you should read **Facilities and Other Providers.** It will help you understand how your choice of doctors and hospitals will affect how much you pay for services under this Plan.

This brochure explains all of your benefits. It's important that you read about your benefits so you will know what to expect when a claim is filed. Most of the benefit headings are self-explanatory. **Other Medical Benefits** and **Additional Benefits,** on the other hand, both include a variety of unrelated benefits. What is different about these benefits is how they are paid: Other Medical Benefits are generally paid after you satisfy the calendar year deductible and Additional Benefits are generally not subject to the calendar year deductible.

You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on which provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a doctor, a physical therapist, or an outpatient facility.

The last part of the brochure contains information useful to you under certain circumstances. For example, if you have to go to the hospital you need to read **Precertification;** generally, hospital stays **must** be precertified for all payable benefits to apply. If you are enrolled in Medicare, take a look at **This Plan and Medicare.** And, the **Enrollment Information** section tells you about several FEHB enrollment requirements that could affect your future coverage.

# Table of Contents

# Table of Contents *continued*

# Help Contain Costs

## You can help

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

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

### Precertification

Precertification evaluates the medical necessity of proposed admissions and the number of days required to treat your condition. You are responsible for ensuring that the precertification requirement is met (except for routine maternity admissions). You or your doctor must check with your Local Plan before being admitted to the hospital. If that doesn't happen, your Plan will reduce benefits by $500. Be a responsible consumer. Be aware of your Plan's cost containment provisions. You can avoid penalties and help keep premiums under control by following the procedures specified on page 41 of this brochure.

### Flexible benefits option

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

### PPO

This Plan has established Preferred provider organization (PPO) arrangements. You can receive covered services from PPO providers at a reduced cost. Be sure to look to see if there are PPO cost savings when you review the benefits described in this brochure. The Local Plan (or for pharmacies, PCS Health Systems, Inc.) is solely responsible for the selection of PPO providers and any questions regarding PPO providers should be directed to the Local Plan (or for pharmacies, PCS Health Systems, Inc.) (see page 52 for more information). Call your Local Plan to obtain the names of PPO providers.

In Minnesota, there are special requirements for participation in the Preferred Gold program under Standard Option. An addendum page is available from the Local Plan that outlines benefit levels and special requirements.

### POS

This Plan offers a Point-of-Service (POS) program under Standard Option in the following Local Plan areas: Georgia, Massachusetts, New Jersey, Ohio (Cincinnati only), and Oklahoma. The POS program provides a higher level of benefits when services are provided or referred by a primary care physician selected by the member, while providing Standard Option non-Preferred benefits for services received without a referral. An addendum and a POS selection form are available from the Local Plans in the areas noted above that outlines service areas, benefit levels, and special requirements of the POS program.

# Facilities and Other Providers

## Covered facilities

Covered facility providers include:

### Freestanding ambulatory facilities

- **Preferred Freestanding Ambulatory Facility**—A facility with which a local Blue Cross Plan has, at the time a member is admitted or receives services, an agreement to render outpatient surgical or renal dialysis care. Other facilities determined to be Preferred facilities by a local Blue Cross Plan are Preferred freestanding ambulatory facilities for purposes of this Plan. Contact your local Blue Cross Plan to find out if the facility you plan to be admitted to, or receive services from, is a Preferred facility.

# Facilities and Other Providers *continued*

### Freestanding ambulatory facilities *continued*

- **Member Freestanding Ambulatory Facility**—A facility with which a local Blue Cross Plan has, at the time a member is admitted or receives services, an agreement to render outpatient surgical or renal dialysis care. Other facilities determined to be Member facilities by a local Blue Cross Plan are Member freestanding ambulatory facilities for purposes of this Plan.
- **Non-Member Freestanding Ambulatory Facility**—A facility that 1) is not a Preferred or Member freestanding ambulatory facility; 2) has permanent facilities and equipment for the primary purpose of performing surgical and/or renal dialysis procedures on an outpatient basis; 3) provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility; 4) does not provide inpatient accommodations; and 5) is not, other than incidentally, a facility used as an office or clinic for the private practice of a physician or other professional.

### Hospitals

- **Preferred Hospital**—A hospital with which a local Blue Cross Plan has, at the time a member is admitted or receives services, an agreement to render hospital services. Other hospitals determined to be Preferred hospitals by a local Blue Cross Plan are Preferred hospitals for purposes of this Plan, including those hospitals in Hawaii determined to be Preferred hospitals by the local Blue Shield Plan. Contact your local Blue Cross Plan to find out if the hospital you plan to be admitted to, or receive services from, is a Preferred hospital.
- **Member Hospital**—A hospital with which a local Blue Cross Plan has, at the time a member is admitted or receives services, an agreement to render hospital services to members. Other hospitals determined to be Member hospitals by a local Blue Cross Plan are Member hospitals for purposes of this Plan, including those hospitals in Hawaii determined to be Member hospitals by the local Blue Shield Plan. Contact your local Blue Cross Plan to find out if the hospital you plan to be admitted to, or receive services from, is a Member hospital.
- **Non-Member Hospital**—A hospital, or distinct part of an institution, that 1) is not a Preferred or Member hospital; 2) for compensation from its patients and on an inpatient basis is engaged primarily in providing diagnostic and therapeutic facilities for surgical and medical diagnoses, treatment, and care of injured and sick persons by or under the supervision of a staff of licensed doctors of medicine (M.D.) or licensed doctors of osteopathy (D.O.); 3) continuously provides 24-hour-a-day professional registered nursing (R.N.) services; and 4) is not, other than incidentally, an extended care facility; a nursing home; a place for rest; an institution for exceptional children, the aged, drug addicts, or alcoholics; or a custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training, or non-medical personal services.

  College infirmaries are considered Non-member hospitals. In addition, the Carrier may, at its discretion, recognize any institution located outside the 50 states and the District of Columbia as a Non-member hospital.

### Skilled nursing facilities

- **Qualified Skilled Nursing Facility**—A facility that:

  1) specializes in skilled care and meets Medicare's special qualifying criteria, and
  2) has the staff and equipment to provide skilled nursing care performed by, or under the supervision of, licensed nursing personnel, or skilled rehabilitation services such as physical therapy performed by, or under the supervision of, a professional therapist, and other related health services.

  The term qualified skilled nursing facility does not include any institution that primarily cares for and treats mental diseases.

### Cancer research facilities

- **Cancer Research Facility**—A facility that is: 1) a National Cooperative Cancer Study Group institution that is funded by the National Cancer Institute (NCI) and has been approved by a Cooperative Group as a bone marrow transplant center; 2) an NCI-designated Cancer Center; or 3) an institution that has an NCI-funded, peer-reviewed grant to study allogeneic bone marrow transplants or autologous bone marrow transplants (autologous stem cell support) and autologous peripheral stem cell support.

### Others

- Others as set forth within the benefits description.

### How facilities are paid

See Definitions for an explanation of Preferred rate, Member rate, Non-member rate, Average charge, and Billed charge under Covered charges.

## Covered providers

Covered professional providers include:

- **Physician**—Doctors of medicine (M.D.), osteopathy (D.O.), dental surgery (D.D.S.), medical dentistry (D.M.D.), podiatric medicine (D.P.M.), and optometry (O.D.), when acting within the scope of their licenses, are considered physicians.
- **Attending Physician**—The physician who has responsibility for the care and treatment of the member on an inpatient basis. A consulting physician who is an employee of the hospital in which the member is an inpatient is not the attending physician.

The following are considered covered providers when they perform covered services within the scope of their license or certification:

- **Independent Laboratory**—A laboratory that is licensed under State law or, where no licensing requirement exists, is approved by the Local Plan.
- **Qualified Clinical Psychologist**—A psychologist who 1) is licensed or certified in the state where the services are performed, 2) has a doctoral degree in psychology or an allied degree if, in the individual state, the academic licensing/certification requirement for clinical psychologist is met by an allied degree, or meets the requirements of the Carrier, and 3) has met the clinical psychological experience requirements of the individual State Licensing Board.
- **Nurse Midwife**—A person who is certified by the American College of Nurse Midwives or is licensed or certified as a nurse midwife in states requiring licensure or certification.
- **Nurse Practitioner/Clinical Specialist**—A person who 1) has an active R.N. license in the United States, 2) has a baccalaureate or higher degree in nursing, and 3) is licensed or certified as a nurse practitioner or clinical nurse specialist in states requiring licensure or certification.
- **Clinical Social Worker**—A social worker who 1) has a master's or doctoral degree in social work, 2) has at least two years of clinical social work practice, and 3) in states requiring licensure, certification, or registration, is licensed, certified, or registered as a social worker where the services are rendered.
- **Nursing School Administered Clinic**—A clinic that is 1) licensed or certified in the state where the services are performed, and 2) provides ambulatory care in an outpatient setting—primarily in rural or inner-city areas where there is a shortage of physicians. Services billed for by these clinics are considered outpatient "office" services rather than facility charges.
- Others as set forth within the benefits description.

### Coverage in medically underserved areas

Within States designated as medically underserved areas, any licensed medical practitioner will be treated as a covered provider for any covered services performed within the scope of that license. For 1997, the States designated as medically underserved are: Alabama, Louisiana, Mississippi, New Mexico, North Dakota, South Carolina, South Dakota, West Virginia, and Wyoming.

### How providers are paid

There are three types of Allowable charges: the Preferred Provider Allowance (PPA), which applies to charges from Preferred professional providers and pharmacies; the Participating Provider Allowance (PAR), which applies to charges from Participating professional providers; and the Non-participating Provider Allowance (NPA), which applies to charges from Non-participating professional providers. (See Definitions for an explanation of Allowable charges under Covered charges, and Preferred, Participating, and Non-participating physicians.) Most Preferred physicians accept 100% of the PPA as payment in full (see page 8 for exceptions). In most cases, when you use a Preferred physician, you are responsible for your coinsurance (after any applicable deductible has been met), and are not responsible for any covered expense in excess of the PPA.

### How providers are paid *continued*

Participating physicians usually accept 100% of the Local Plan's PAR as payment in full. That means when you use a Participating physician, you are usually only responsible for your coinsurance for covered services (after any applicable deductible has been met), and are not responsible for any covered expense in excess of the PAR. In some Plan areas, physicians who were formerly Participating physicians are now Preferred physicians for the purposes of this Plan.

In the following areas, there are Preferred physicians but no Participating physicians for the purposes of either option of this Plan:

Alabama
Alaska
Connecticut
Hawaii
Illinois
Mississippi
New Jersey
New York areas served by the Empire Plan
Puerto Rico
South Carolina
Tennessee
Utah

Non-participating physicians, on the other hand, may, but are not required to, accept the Local Plan's NPA as payment in full. These physicians may bill you up to their charge, even after the Local Plan has paid its portion of your bill. Members may be held responsible for any amounts over the NPA, in addition to applicable coinsurance amounts, copayment amounts, amounts applied to the calendar year deductible, and noncovered services. **It is important that you are aware that your out-of-pocket costs may be higher when you use Non-participating physicians.**

### When this Plan pays primary or secondary benefits

In all Local Plan areas other than those described below, Preferred physicians will accept 100% PPA as payment in full and Participating physicians will accept 100% PAR as payment in full for covered services. As a result, members are only responsible for applicable coinsurance amounts, copayment amounts, amounts applied to the calendar year deductible, and noncovered services. Any balance above the applicable Allowable charge (PPA or PAR) billed by a Preferred or Participating physician under either **High Option** or **Standard Option** should be brought to the attention of the Local Plan.

#### Exceptions when this Plan pays primary

- In Arizona and New York areas served by the Syracuse Plan, if there is secondary coverage not administered by this Plan, or other source of payment, Preferred and Participating physicians are not obligated to accept the PPA or PAR as payment in full.

#### Exceptions when this Plan pays secondary

- In Connecticut and Puerto Rico, Preferred physicians can collect the difference between the Plan's payment and the physician's charge.
- In Montana, Preferred and Participating physicians can collect the difference between the Plan's payment and the physician's charge.
- In Pennsylvania and Utah, the agreement described above applies only when the Local Plan makes a payment as the secondary payer to other coverage (see pages 11-13).
- In the following areas, Preferred and Participating physicians can collect the difference between the Plan's payment and the physician's charge except when this Plan pays secondary to other Blue Cross and Blue Shield coverage:

  Arizona*
  Arkansas*
  Idaho areas served by the Boise Plan
  New Mexico*
  New York areas served by the Rochester* and Syracuse* Plans
  Rhode Island
  South Carolina
  Vermont
  West Virginia*

  *The above agreement applies only when the primary coverage is administered by the same Local Plan.

### Areas outside the United States and Puerto Rico

The Washington, DC Plan processes overseas claims at the Preferred benefit level as indicated on page 37, and pays the member based on the amounts Participating providers in the Washington, DC area are accepting as payment in full.

# Cost Sharing

## Deductibles

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

### Calendar year

The calendar year deductible is the amount of expenses an individual must incur for covered services and supplies each calendar year before the Plan pays certain benefits. The calendar year deductible is $150 per person under **High Option** and $200 per person under **Standard Option**. The calendar year deductible applies to all covered services and supplies except for certain Inpatient Hospital Benefits, Facility Benefits—Outpatient Surgery, Additional Benefits, Prescription Drug Benefits, **Standard Option** Dental Benefits, or, under **High Option**, Surgical Benefits and Maternity Benefits.

If the Billed charge for services you receive is less than the remaining portion of your deductible, you pay the Billed charge. If the Billed charge is more than the remaining portion of your deductible, you pay the remaining portion, and you and the Plan pay the stated percentage of the amount of the Covered charge remaining, if any (see the discussion of coinsurance on page 10).

If you change options in this Plan during the calendar year, the amount of covered expenses already applied toward the deductible of your old option will be credited to the deductible of your new option.

### Hospital admission

The per admission deductible is the amount of covered hospital room and board expenses an individual must incur during each Non-preferred hospital admission before the Plan pays benefits. The per admission deductible is $100 under **High Option** and $250 under **Standard Option**.

### Prescription drugs

The prescription drug deductible is the amount of covered retail pharmacy-obtained drug expenses an individual must incur each calendar year before the Plan pays retail pharmacy drug benefits. The prescription drug deductible is $50 per person under **High** and **Standard Options**. Prescription drugs not obtained from a retail pharmacy, such as those provided to you by your physician, are eligible for Other Medical Benefits and are subject to the calendar year deductible.

Drugs obtained through the Mail Service Prescription Drug Program are not subject to any deductible and are eligible for benefits only as described on page 33.

### Carryover

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

### Family limit

There is a separate calendar year deductible of $150 per person under **High Option** and $200 per person under **Standard Option**, as well as a prescription drug deductible of $50 per person under **High** and **Standard Options**. However, under a family enrollment, when the combined covered expenses applied to the calendar year deductible for family members reach $300 under **High Option** and $400 under **Standard Option** during a calendar year, the family calendar year deductible is satisfied and benefits for which the calendar year deductible applies are payable for all family members.

Similarly, under a family enrollment, when the combined covered retail pharmacy-obtained drug expenses applied to the prescription drug deductible for family members reach $100 under **High Option** or **Standard Option** during a calendar year, the family prescription drug deductible is satisfied and retail pharmacy-obtained drug expenses are payable for all family members.

# Cost Sharing *continued*

## Coinsurance

Coinsurance is the stated percentage of Covered charges you must pay after you have met any applicable deductibles. For instance, when the Plan pays 80% of the Allowable charge (see Definitions) for a covered service, you are responsible for the coinsurance, which is 20% of the Allowable charge. In addition, you will be responsible for any excess charge over the Plan's Allowable charge when you use a Non-participating physician. For example, if a Non-participating physician ordinarily charges $100 for a service, but the Plan's Allowable charge is $95, the Plan will pay 80% of the Allowable charge ($76). You must pay the 20% coinsurance of the Allowable charge ($19), plus the difference between the Billed charge and the Allowable charge ($5), for a total member responsibility of $24. Remember, if you use Preferred or Participating physicians, your share of Covered charges (after meeting any deductible) is limited to the stated coinsurance amounts based on the Allowable charge in most Local Plan areas (see page 8 for exceptions). If you use Non-participating physicians, your out-of-pocket costs will be higher, as shown in the example above.

Your local Blue Cross and Blue Shield Plan negotiates payment arrangements with Preferred and Member hospitals and other facilities, and with Preferred and Participating physicians and other professional providers, that result in overall cost containment. The amounts these providers agree to accept as payment in full are generally, but not always, lower than the Billed charge (see Definitions for an explanation of Preferred and Member rates, Preferred and Participating Provider Allowances, and Billed charge under Covered charges). For services of these providers, your coinsurance will be based on the lesser of the Billed charge or the negotiated amount that these providers have agreed to accept, including any savings the Local Plan realizes through discounts that are known and that can be accurately calculated at the time your claim is processed. If you are age 65 or older and not enrolled in Medicare, this may not apply (see page 12). If you use Non-member facilities for inpatient care, the Plan will pay its percentage based on the Billed charge or Average charge (see Definitions under Covered charges). You will be responsible for the coinsurance calculated on the Billed charge or Average charge and any excess charge over the Average charge.

## Copayments

A copayment is the stated amount the Plan may require you to pay for a covered service, such as $12 per prescription by mail or $10 per office visit charge at a Preferred physician. For instance, when you visit a Preferred physician for a covered service, after you pay the $10 copayment, the Plan pays the remainder of the Preferred Provider Allowance (PPA).

For outpatient facility care and inpatient and outpatient mental conditions/substance abuse care in Preferred and Member hospitals, you are responsible for the least of the sum of the applicable per day copayments, the Billed charge, or the Preferred or Member rate, after you have met any applicable deductibles. For example, if you receive four days of inpatient mental condition care at a Member hospital for which your copayments are $1,000 (4 x $250), the Billed charge is $900, and the Member rate is $800, you will be responsible for the Member rate ($800). For Non-member facilities, you will be responsible for the lesser of the sum of your copayments or the Billed charge.

### If provider waives your share

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

## Lifetime maximums

Under **both options**, benefits are limited to $100 per person per lifetime for one smoking cessation treatment program (see page 28).

Under **both options**, inpatient care for treatment of alcoholism and drug abuse is limited to one treatment program (28-day maximum) per person per lifetime (see page 24).

When an enrollee changes options within the Blue Cross and Blue Shield Service Benefit Plan, each enrollee and covered family member is entitled to new benefits subject to the deductibles, limitations, exclusions, and definitions of the new option. Benefit amounts accrued under **High Option** or **Standard Option** are accumulated in a permanent record regardless of the number of enrollment changes.

# General Limitations

All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable when determined by the Carrier to be medically necessary. Coverage is provided only for services and supplies that are listed in this brochure. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under the Plan or be used in the prosecution or defense of a claim under the Plan.** This brochure is based on text included in the contract between OPM and this Plan and is intended to be the complete statement of benefits available to FEHB members. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control.

## Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Carrier and complete all necessary documents and authorizations requested by the Carrier.

### Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B, or Parts A and B of Medicare, the provisions on coordination of benefits with Medicare described on pages 43-45 apply.

### Group health insurance and automobile insurance

Coordination of benefits (double coverage) applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Carrier.

When there is double coverage, one plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of 1) its benefits in full, or 2) a reduced amount that, when added to the benefits payable by the other coverage, will not exceed 100% of the Covered charges for the service.

The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners (NAIC). When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have.

This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Carrier to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

### CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first.

### Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

### Workers' compensation

The Plan will not pay for benefits or services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, medical benefits may be provided for services or supplies covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for benefits paid by the Plan that were later found to be payable by OWCP (or the agency).

### DVA facilities, DoD facilities and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

### Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

### Liability insurance and third party actions

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

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

When you or your dependent make a claim against a third party or the third party's insurer as a result of an injury or illness for which that third party is legally responsible, the Plan shall have a lien on the proceeds of that claim in order to reimburse itself to the full amount of benefits it is called upon to pay. The Plan's lien will apply to any and all recoveries for such claim whether by court order or out-of-court settlement.

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

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

## Overpayments

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

## Vested rights

An enrollee does not have a vested right to receive the benefits in this brochure in 1998 or later years, and does not have a right to benefits available prior to 1997 unless those benefits are contained in this brochure.

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

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

### Inpatient hospital care

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

# General Limitations *continued*

**Physician services**

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

The Plan is required to base its payment on the Medicare-approved amount (which is the Medicare fee schedule for the service), **or** the actual charge, whichever is lower. If your physician is a member of the Plan's Preferred Provider Organization (PPO) and participates with Medicare, the Plan will base its payment on the lower of these two amounts and you are responsible only for any deductible and the PPO copayment or coinsurance.

If you go to a PPO physician who does not participate with Medicare, you are responsible for any deductible and the copayment or coinsurance. In addition, you must pay the difference between the Medicare-approved amount and the limiting charge (115% of the Medicare-approved amount).

If your physician is not a Plan PPO physician but participates with Medicare, the Plan will base its regular benefit payment on the Medicare-approved amount. For instance, under this Plan's Standard Option surgical benefit, the Plan will pay 75% of the Medicare-approved amount. You will only be responsible for any deductible and coinsurance equal to 25% of the Medicare-approved amount.

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

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

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

# General Exclusions

These exclusions apply to more than one or to all benefits categories. Exclusions that are primarily identified with a single benefit category are listed along with that benefit category, but may apply to other categories. Therefore, please refer to the specific benefit sections as well to assure that you are aware of all benefit exclusions.

Benefits are provided only for services and supplies that are medically necessary (see definition). The Carrier reserves the right to determine medical necessity. The fact that a covered provider has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary.

## Benefits will not be paid for services and supplies when:

- No charge would be made if the covered individual had no health insurance coverage
- Furnished without charge (except as described on page 11); while in active military service; or required for illness or injury sustained on or after the effective date of enrollment 1) as a result of an act of war within the United States, its territories, or possessions or 2) during combat
- Furnished by immediate relatives or household members, such as spouse, parent, child, brother, or sister, by blood, marriage, or adoption
- Furnished or billed by a provider or facility that has been barred from the FEHB Program
- Furnished or billed by a noncovered facility, except that medically necessary prescription drugs are covered
- For or related to sex transformation, sexual dysfunction, or sexual inadequacy
- Not specifically listed as covered
- Experimental or investigational (see Definitions), except for the clinical trials benefit on page 19
- Not provided in accordance with accepted professional medical standards in the United States

## Benefits will not be paid for:

- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copay, or coinsurance, the Carrier will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.
- Charges the enrollee or Plan has no legal obligation to pay, such as: excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see pages 12-13), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 44), or State premium taxes however applied.
- In the case of inpatient care, medical services which are not medically necessary, *i.e.*, those which did not require the acute hospital inpatient (overnight) setting, but could have been provided in a physician's office, the outpatient department of a hospital, or some other setting, without adversely affecting the patient's condition or the quality of medical care rendered. Some examples are:
  - admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, *e.g.*, physician's office
  - admissions primarily for diagnostic studies (X-ray, *e.g.*, Magnetic Resonance Imagings-MRIs, laboratory, and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, *e.g.*, outpatient department of a hospital or physician's office
- Standby physicians
- Biofeedback and other forms of self-care or self-help training, including cardiac rehabilitation, and any related diagnostic testing
- Any dental and oral surgical procedures involving orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for the fitting or the continued use of dentures. These are covered only as described under **Standard Option** Dental Benefits, Dental care for accidental injury, Hospitalization for dental work, or Surgical Benefits for Oral and maxillofacial surgery
- Custodial care (see Definitions)
- Services and supplies furnished or billed by an extended care facility, nursing home, or other noncovered facility, except as specifically described on page 31. Medically necessary prescription drugs are covered
- Eyeglasses, contact lenses, routine eye examinations, or vision testing for the prescribing or fitting of eyeglasses or contact lenses, except as provided for on page 27
- Eye exercises, visual training, or orthoptics, except for nonsurgical treatment of amblyopia and strabismus as described on page 27
- Hearing aids or examinations for the prescribing or fitting of hearing aids
- Treatment of obesity, weight reduction, or dietary control, except for gastric bypass surgery or gastric stapling procedures
- Personal comfort items such as beauty and barber services, radio, television, or telephone
- Services or supplies used for cosmetic purposes
- Routine services (see Definitions), except for those Preventive services specifically described in this brochure on pages 25, 26, and 29. For purposes of this Plan, routine services include, but are not limited to, periodic physical examinations, screening examinations or tests, immunization shots, and X-rays, Magnetic Resonance Imagings—MRIs, laboratory and pathological services, and machine diagnostic tests that are not related to a specific diagnosis, illness, injury, set of symptoms, or maternity care
- Routine foot care, including corn or callus removal, or nail trimming
- Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay or through an approved Home health care program
- Assisted Reproductive Technology (ART) procedures and related services and supplies (see page 22)
- Services rendered by noncovered providers such as chiropractors, except in medically underserved areas
- 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

# Inpatient Hospital Benefits

## What is covered

The Plan pays for inpatient hospital services as shown below.

### Precertification

The medical necessity of your hospital admission **must** be precertified for you to receive full Plan benefits. Emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See page 41 for details.

### Waiver

This precertification requirement does not apply to persons whose primary coverage is Medicare Part A or another health insurance policy or when the hospital admission is outside the United States. For information on when Medicare is primary, see pages 43-45.

### Room and board and Other charges

The Plan provides coverage at the benefit levels indicated below for services provided by the following facilities when furnished and billed as regular inpatient hospital services:

| | High Option | Standard Option |
|---|---|---|
| PPO/Preferred hospitals | With no per admission deductible, Plan pays **in full** for unlimited days | With no per admission deductible, Plan pays **in full** for unlimited days |
| Member hospitals | After you pay a $100 per admission deductible, Plan pays **in full** for unlimited days | After you pay a $250 per admission deductible, Plan pays **in full** for unlimited days |
| Non-member hospitals | After you pay a $100 per admission deductible under **High Option** or a $250 per admission deductible under **Standard Option**, hospital charges in the United States and Puerto Rico are paid at **70%** of the **Non-member rate** (see definition), or the per diem charge **in full** after the per admission deductible in U.S. Public Health Service and Armed Forces Hospitals. The Plan pays **in full** for facilities outside of the United States and Puerto Rico with no per admission deductible. | |

**Note:** You should be aware that some Preferred hospitals may have Non-preferred providers on staff. Following is a list of some of the frequently referred providers about whose Preferred status you should inquire to help ensure that you receive your maximum benefits: Radiologist, Pathologist, Anesthesiologist, and Assistant Surgeon.

### Room and board

Covered services are noted below:

- Semiprivate accommodations
- Intensive care units

### Private room

A private room is covered only when the patient's isolation is required by law, or the Carrier determines that isolation is medically necessary to prevent contagion.

In noncovered private accommodations and in other noncovered accommodations, the Plan pays the hospital's average daily rate for semiprivate accommodations, which is determined by the Local Plan. Other hospital services are paid as shown above.

# Inpatient Hospital Benefits *continued*

### Other hospital charges

- Operating, recovery, and other treatment rooms
- Drugs and medical supplies
- X-ray (*e.g.*, Magnetic Resonance Imagings-MRIs), laboratory, and pathological services, and machine diagnostic tests
- Dressings, splints, plaster casts
- Anesthetics and anesthesia service
- Administration of blood and blood plasma but not the blood itself
- Pre-admission testing recognized as part of the hospital admissions procedures

## Limited benefits

### Hospitalization for dental work

The Plan pays for room and board and other hospital services for hospitalization in connection with dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient.

### Chemotherapy/ radiation therapy

Chemotherapy and/or radiation therapy when supported by allogeneic or autologous bone marrow transplants or autologous stem cell support is only covered for specific diagnoses (see Organ/tissue transplants under Surgical Benefits on page 19).

## Related benefits

### Outpatient hospital benefits

See page 25 for outpatient hospital care benefits and outpatient surgery/facility care benefits.

### Surgical benefits

See page 18 for surgical benefits when provided, or ordered, and billed by a physician.

### Other charges

See Other Medical Benefits for coverage of blood, drugs, and ambulance services.

## Inhospital physician care

The Plan provides coverage at the benefit levels indicated below for the following nonsurgical services provided, or ordered, and billed by a physician:

| | High Option | Standard Option |
|---|---|---|
| PPO/Preferred physicians | Plan pays **95% PPA** | After you pay the $200 calendar year deductible, Plan pays **95% PPA** |
| Participating physicians | Plan pays **80% PAR** | After you pay the $200 calendar year deductible, Plan pays **75% PAR** |
| Non-participating physicians | Plan pays **80% NPA**. The member is responsible for the difference between the Plan's payment and the physician's actual charge | After you pay the $200 calendar year deductible, Plan pays **75% NPA**. The member is responsible for the difference between the Plan's payment and the physician's actual charge |

See Definitions for an explanation of: Preferred, Participating, and Non-participating physicians, and PPA, PAR, and NPA under Covered charges.

- Medical care by the attending physician on days covered by Inpatient Hospital Benefits
- Intensive physician care by the attending physician for treatment of a condition other than that for which surgical or maternity care is required
- Consultations when requested by the attending physician, not including routine radiological and staff consultations required by hospital rules and regulations
- Concurrent care (see Definitions)
- Physical therapy when provided by a physician other than the attending physician

## What is not covered

Room and board and inhospital physician care when, in the Carrier's judgment, a hospital admission or portion of an admission is one of the following types:

- Custodial care (see Definitions)
- Convalescent care or a rest cure
- Domiciliary care provided because care in the home is not available or is unsuitable
- Inpatient private duty nursing
- Not medically necessary, *i.e.*, for services which did not require the acute hospital inpatient (overnight) setting, but could have been provided in a physician's office, the outpatient department of a hospital, or some other setting, without adversely affecting the patient's condition or the quality of medical care rendered. Some examples are:
  - — admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, *e.g.*, physician's office
  - — admissions primarily for diagnostic studies (X-ray, *e.g.*, Magnetic Resonance Imagings-MRIs, laboratory, and pathological services, and machine diagnostic tests) which could have been provided safely and adequately in some other setting, *e.g.*, outpatient department of a hospital or physician's office

If a hospital admission is determined to be one of the types listed above, the Plan will pay benefits for services or supplies other than room and board and inhospital physician care at the level at which they would have been covered if provided in some other setting.

# Surgical Benefits

## What is covered

The Plan provides coverage at the benefit levels indicated below, except as noted, for the following services provided, or ordered, and billed by a physician:

| | High Option | Standard Option |
|---|---|---|
| PPO/Preferred physicians | Plan pays **95% PPA** | After you pay the $200 calendar year deductible, Plan pays **95% PPA** |
| Participating physicians | Plan pays **80% PAR** | After you pay the $200 calendar year deductible, Plan pays **75% PAR** |
| Non-participating physicians | Plan pays **80% NPA**. The member is responsible for the difference between the Plan's payment and the physician's actual charge | After you pay the $200 calendar year deductible, Plan pays **75% NPA**. The member is responsible for the difference between the Plan's payment and the physician's actual charge |

See Definitions for an explanation of: Preferred, Participating, and Non-participating physicians, and PPA, PAR, and NPA under Covered charges.

## Surgical services

- Operative or cutting procedures, including treatment of fractures and dislocations, surgical sterilization, and normal pre- and post-operative care by the operating physician
- Diagnostic procedures such as endoscopies and biopsies
- Treatment of burns
- Surgical correction of congenital anomalies (see Definitions)
- Extraction or reinfusion of bone marrow or blood stem cells as part of an allogeneic or autologous bone marrow transplant or autologous stem cell support procedure, including marrow harvesting in anticipation of a covered autologous bone marrow transplant, for patients diagnosed at the time of harvesting with one of the conditions listed on page 19. Expenses for storage of harvested bone marrow are not covered, unless the covered transplant has already been scheduled
- When unusual circumstances require removal of casts or sutures by a physician other than the one who applied them, the Local Plan may determine that a separate allowance is payable
- Surgical correction of amblyopia and strabismus

### Multiple surgical procedures

When multiple or bilateral surgical procedures that add time or complexity to patient care are performed during the same operative session, the Plan pays these multiple, bilateral, or incidental surgical (combined) procedures on the basis of the Allowable charge that is determined by the Local Plan. The Plan determines which procedure is primary and which procedures are secondary, tertiary, etc., and provides a reduced allowance for the non-primary procedures.

### Assistant surgeon (inpatient/outpatient)

Surgical assistance by a physician if required by the complexity of the surgical procedure.

### Anesthesia (inpatient/outpatient)

Anesthesia service when requested by the attending physician and performed by a certified registered nurse anesthetist (CRNA) or a physician, other than the operating physician or the assistant, for covered surgical services. CRNAs are reimbursed at the payment levels indicated above for Participating and Non-participating physicians.

## Organ/tissue transplants and donor expenses

**What is covered**

The following human organ/tissue transplant procedures:

- Allogeneic bone marrow for 1) Acute lymphocytic or nonlymphocytic (*i.e.*, myelogenous) leukemia; 2) Advanced Hodgkin's lymphoma; 3) Advanced non-Hodgkin's lymphoma; 4) Advanced neuroblastoma; 5) Chronic myelogenous leukemia; 6) Infantile malignant osteopetrosis; 7) Severe combined immunodeficiency; 8) Wiskott-Aldrich syndrome; 9) Mucopolysaccharidosis (*e.g.*, Hunter, Hurler's, Sanfilippo, Maroteaux-Lamy variants); 10) Mucolipidosis (*e.g.*, Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy); 11) Severe or very severe aplastic anemia; 12) Advanced forms of myelodysplastic syndromes; and 13) Thalassemia major (homozygous beta-thalassemia)
- Autologous bone marrow (autologous stem cell support) and autologous peripheral stem cell support for 1) Acute lymphocytic or nonlymphocytic (*i.e.*, myelogenous) leukemia; 2) Advanced Hodgkin's lymphoma; 3) Advanced non-Hodgkin's lymphoma; 4) Advanced neuroblastoma; 5) Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors; and 6) Multiple myeloma
- Allogeneic bone marrow and allogeneic peripheral stem cell support for Multiple myeloma; and autologous bone marrow (autologous stem cell support) and autologous peripheral stem cell support for 1) Breast cancer and 2) Epithelial ovarian cancer; only when performed as part of a clinical trial that meets the requirements noted in the Limitations below and is conducted at a Cancer Research Facility (see page 6). In the event no non-randomized clinical trials meeting the requirements set forth below are available at Cancer Research Facilities for a member eligible for such clinical trials, the Plan will make arrangements for the transplant to be provided at another Plan-designated transplant facility

Related services or supplies provided to the recipient are covered, including chemotherapy and/or radiation therapy when supported by allogeneic or autologous bone marrow transplants or autologous stem cell support, and drugs or medications administered to stimulate or mobilize stem cells for the transplant procedures described above.

- Single or double lung transplants for the following end-stage pulmonary diseases: 1) Pulmonary fibrosis, 2) Primary pulmonary hypertension, and 3) Emphysema. Double lung transplant for end-stage cystic fibrosis.
- Cornea
- Heart
- Heart-lung
- Kidney
- Liver
- Pancreas

Related medical and hospital expenses of the donor are covered.

**Limitations**

- Prior approval by the Local Plan of the procedure and the facility is required for bone marrow, heart, heart-lung, liver, lung, and pancreas transplants (see page 42)
- For the bone marrow transplant procedures and related services or supplies covered only through clinical trials:
  1) Prior approval by the Carrier is required (see page 42);
  2) The clinical trial must be reviewed and approved by the Institutional Review Board of the Cancer Research Facility where the procedure is to be delivered; and
  3) The patient must be properly and lawfully registered in the clinical trial, meeting all the eligibility requirements of the trial

**What is not covered**

- Services or supplies for or related to artificial or human organ/tissue transplants for any diagnosis not specifically listed as covered. Related services or supplies for noncovered procedures, including chemotherapy and/or radiation therapy when supported by allogeneic or autologous bone marrow transplants or autologous stem cell support, drugs or medications administered to stimulate or mobilize stem cells for transplant, and all other services or supplies which would not be medically necessary or appropriate but for the noncovered procedure.

### Oral and maxillofacial surgery

Limited to the following surgical procedures:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth when pathological examination is required
- Surgery needed to correct accidental injuries (see Definitions) to jaws, cheeks, lips, tongue, roof and floor of mouth
- Excision of exostoses of jaws and hard palate
- External incision and drainage of cellulitis
- Incision and surgical treatment of accessory sinuses, salivary glands or ducts
- Reduction of dislocations and excision of temporomandibular joints
- Removal of impacted teeth

### Reconstructive surgery

Reconstructive surgery, including breast reconstruction following mastectomy and treatment to restore the mouth to a pre-cancer state.

## Related benefits

### Outpatient surgery/ facility care benefits

Outpatient surgical services billed for by a facility are covered under Other Medical Benefits. See page 25.

## What is not covered

- Cosmetic surgery (see Definitions) unless required for a congenital anomaly or to restore or correct a part of the body which has been altered as a result of accidental injury, disease, or surgery which occurred while the member was covered by a plan under the FEHB Program
- Radial keratotomy
- Services for or related to reversal of surgical sterilization

# Maternity Benefits

## What is covered

The Plan provides coverage at the benefit levels indicated below for services provided by the following facilities when furnished and billed as regular inpatient hospital services:

### Inpatient hospital

**Precertification**

Precertification is **not** required for maternity admissions for routine deliveries. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 72 hours after a cesarean section, your physician or the hospital must contact the Local Plan for certification of additional days. The Plan will not pay for charges incurred on any extra days that have not been certified. See pages 41-42 for details.

| | High Option | Standard Option |
|---|---|---|
| PPO/Preferred hospitals | With no per admission deductible, Plan pays **in full** for unlimited days | With no per admission deductible, Plan pays **in full** for unlimited days |
| Member hospitals | After you pay a $100 per admission deductible, Plan pays **in full** for unlimited days | After you pay a $250 per admission deductible, Plan pays **in full** for unlimited days |
| Non-member hospitals | After you pay a $100 per admission deductible under **High Option** or a $250 per admission deductible under **Standard Option**, hospital charges in the United States and Puerto Rico are paid at **70%** of the **Non-member rate** (see definition), or the per diem charge **in full** after the per admission deductible in U.S. Public Health Service and Armed Forces Hospitals. The Plan pays **in full** for facilities outside of the United States and Puerto Rico with no per admission deductible. | |

Covered services are noted below:

**Room and board**

Room and board and other hospital services. (See Inpatient Hospital Benefits for a description of all covered services, and payment levels for Non-member hospitals.)

**Private room**

A private room is covered only when the patient's isolation is required by law, or the Carrier determines that isolation is medically necessary to prevent contagion.

In noncovered private accommodations and in other noncovered accommodations, the Plan pays the hospital's average daily rate for semiprivate accommodations, which is determined by the Local Plan. Other hospital services are paid as shown above.

**Bassinet and nursery**

Hospital bassinet or nursery charges for days in which both the mother and newborn are confined in the hospital are considered as expenses of the mother and not expenses of the child. When a newborn requires definitive treatment (including incubation charges by reason of prematurity), or evaluation for medical or surgical reasons, during or after the mother's confinement, the newborn is considered a patient in his or her own right and a separate per admission deductible, if applicable, applies. Expenses of the newborn (including circumcision) are eligible for benefits only if the child is covered by a Self and Family enrollment. See pages 41-42 for information on requesting additional days for a covered newborn confined beyond the mother's discharge date.

**Other charges**

- Operating, recovery, and other treatment rooms
- Drugs and medical supplies
- Other covered ancillary services

### Outpatient care

Outpatient hospital care for delivery including care in freestanding ambulatory facilities, including birthing centers, is covered as described under Other Medical Benefits, Outpatient surgery—Facility care benefits (see pages 25-26).

- **Note**: When you use Preferred facilities, benefits for obstetrical care, including prenatal testing, are provided **in full**, not subject to the calendar year deductible.

# Maternity Benefits *continued*

### Professional care

The Plan provides coverage at the benefit levels indicated below for services provided, or ordered, and billed by a physician or nurse midwife:

| | High Option | Standard Option |
|---|---|---|
| PPO/Preferred physicians | Plan pays **in full** | Plan pays **in full** |
| Participating physicians/Nurse midwives | Plan pays **80% PAR** | After you pay the $200 calendar year deductible, Plan pays **75% PAR** |
| Non-participating physicians/Nurse midwives | Plan pays **80% NPA**. The member is responsible for the difference between the Plan's payment and the physician's actual charge | After you pay the $200 calendar year deductible, Plan pays **75% NPA**. The member is responsible for the difference between the Plan's payment and the physician's actual charge |

See Definitions for an explanation of: Preferred, Participating, and Non-participating physicians, and PAR and NPA under Covered charges.

### Obstetrical care

- Physician care for pregnancy (including related conditions) and resulting childbirth or miscarriage
- Services of a licensed or certified nurse midwife for pre- and post-partum care and delivery
- Anesthesia services, services of a nurse anesthetist, and surgical assistance as described under Surgical Benefits

## Related benefits

### Contraceptive devices and drugs

- Intrauterine devices (IUDs), Norplant, Depo-Provera, and oral contraceptives obtained from a physician are covered at the levels indicated on page 18; when obtained from a facility, they are covered at Other Medical Benefit levels (see page 25)
- IUDs, Norplant, Depo-Provera, and oral contraceptives dispensed by a retail pharmacy are covered as prescription drugs (see page 32)
- Oral contraceptives are also covered under the Mail Service Prescription Drug Program (see page 33)

### Diagnosis and treatment of infertility

Diagnosis and treatment of infertility are covered at the benefit levels indicated on page 18; related prescription drugs are covered under Prescription Drug Benefits (see pages 32-33); see exclusion below for Assisted Reproductive Technology (ART) procedures.

### Prenatal testing

Prenatal testing is covered at the benefit levels shown above and on page 25.

### Voluntary sterilization

Sterilization procedures (see page 18 for benefits for surgical sterilization).

### Well child care

Well child care is covered under Additional Benefits (see page 29).

## For whom

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

## What is not covered

- Assisted Reproductive Technology (ART) procedures, such as artificial insemination, in vitro fertilization, embryo transfer, and GIFT, as well as services and supplies related to ART procedures, including sperm banking
- Reversal of voluntary sterilization
- Contraceptive devices, except as specifically described above



**The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.**

# Mental Conditions/Substance Abuse Benefits

## What is covered

The Plan provides coverage at the benefit levels indicated below for services provided by the following facilities and professionals when furnished and billed as regular inpatient hospital services:

### Mental conditions

#### Inpatient care

**Precertification**

The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive full Plan benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See page 41 for details.

**Hospital care**

| | High Option | Standard Option |
|---|---|---|
| PPO/Preferred hospitals | After you pay a $75 per day copayment, Plan pays the remainder of the **Preferred rate** up to 120 days | After you pay a $150 per day copayment, Plan pays the remainder of the **Preferred rate** up to 100 days |
| Member hospitals | After you pay a $150 per day copayment, Plan pays the remainder of the **Member rate** up to 120 days | After you pay a $250 per day copayment, Plan pays the remainder of the **Member rate** up to 100 days |
| Non-member hospitals | After you pay a $300 per day copayment, Plan pays the remainder of the **Non-member rate** up to 120 days | After you pay a $400 per day copayment, Plan pays the remainder of the **Non-member rate** up to 100 days |

After you pay the per day copayments, the Plan pays the remainder of the Preferred rate, Member rate, or Non-member rate in excess of the sum of your copayments. In Preferred and Member hospitals, in some instances, when the Preferred or Member rate or the Billed charge is less than the sum of your copayments, you will be responsible only for the lowest amount. In Non-member hospitals, in some instances, the Average charge may be less than the sum of your copayments.

See the definition of Covered charges for an explanation of Preferred rate, Member rate, Non-member rate, Billed charge, and Average charge. See also the discussion of copayments in Cost Sharing on page 10.

Covered services include room and board and other hospital services (see Inpatient Hospital Benefits for a description of all covered services).

**Inpatient visits**

The Plan provides coverage at the benefit levels indicated below for inpatient mental conditions and substance abuse professional care rendered by Participating and Non-participating providers:

| High Option | Standard Option |
|---|---|
| After you pay the $150 calendar year deductible, Plan pays **80%** of the **Allowable charge** (see Definitions) | After you pay the $200 calendar year deductible, Plan pays **60%** of the **Allowable charge** (see Definitions) |

# Mental Conditions/Substance Abuse Benefits *continued*

**Outpatient care**

The Plan pays all covered outpatient care (including related services and supplies, such as psychological testing) for the treatment of a mental condition, including substance abuse, as follows:

**Facility care**

| | High Option | Standard Option |
|---|---|---|
| | After satisfaction of the $150 calendar year deductible, Plan pays **in full**, subject to the following copayments: | After satisfaction of the $200 calendar year deductible, Plan pays **in full**, subject to the following copayments: |
| PPO/Preferred facilities | You pay $10 | You pay $25 |
| Member facilities | You pay $50 | You pay $100 |
| Non-member facilities | You pay $100 | You pay $150 |

These copayments will be applied per facility per day, not per service. After meeting the deductibles, you will be responsible for the lesser of the stated copayment or the Billed charge(s). If Preferred or Member facilities are available, and utilized, you will be responsible for the lesser of the stated copayments, the Billed charge(s), or the Preferred or Member rate at the time your claim is processed.

**Professional care**

The Plan provides coverage at the benefit levels described below for outpatient mental conditions and substance abuse professional care rendered by Participating and Non-participating providers:

| High Option | Standard Option |
|---|---|
| After you pay the $150 calendar year deductible, Plan pays **70%** of the **Allowable charge** (see Definitions) | After you pay the $200 calendar year deductible, Plan pays **60%** of the **Allowable charge** (see Definitions) |

**Therapy**

Outpatient visits are available up to **50 visits** under **High Option** and **25 visits** under **Standard Option** per person per calendar year for:

- Individual or group therapy, up to two hours per day, including collateral visits with members of the patient's immediate family, provided by a physician, qualified clinical psychologist, psychiatric nurse, or clinical social worker
- Day-night hospital services (sometimes called partial hospitalization)
- Pharmacotherapy (see page 32 for coverage for prescription drugs obtained from a pharmacy)

The number of visits for which you receive reimbursement will be reduced if these services are used to meet part or all of your calendar year deductible.

## Substance abuse

**Inpatient care**

The Plan provides benefits for the inpatient treatment of alcoholism and drug abuse at the levels indicated on the previous page for hospital care and inpatient visits for mental conditions care. Treatment is also payable in a freestanding alcoholism facility approved by the Local Plan.

**Lifetime maximum**

Inpatient care for the treatment of alcoholism and drug abuse is limited to one treatment program (28-day maximum) per lifetime under **both options**.

**Outpatient care**

The Plan provides benefits for outpatient facility and professional care for the treatment of substance abuse at the benefit levels indicated above. Outpatient visits accrue toward the visit limits described above.

## What is not covered

- Marital, family, educational, or other counseling or training services
- Services rendered or billed by a school or halfway house or a member of its staff
- Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present
- Services and supplies that are not medically necessary (see Definitions and General Exclusions)



**The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.**

# Other Medical Benefits

## What is covered

Except as noted, after any applicable deductibles and copayments have been met, the Plan pays the following:

### Outpatient facility care

| | High Option | Standard Option |
|---|---|---|
| | After satisfaction of the $150 calendar year deductible, Plan pays **in full**, subject to the following copayments: | After satisfaction of the $200 calendar year deductible, Plan pays **in full**, subject to the following copayments: |
| PPO/Preferred facilities | You pay $10 | You pay $25 |
| Member facilities | You pay $50 | You pay $100 |
| Non-member facilities | You pay $100 | You pay $150 |

These copayments will be applied per facility per day, not per service. After meeting the deductible, you will be responsible for the lesser of the stated copayments or the Billed charge(s). If Preferred or Member facilities are available, and utilized, you will be responsible for the lesser of the stated copayments, the Billed charge(s), or the Preferred or Member rate at the time your claim is processed.

Covered services, 1) when furnished by the hospital outpatient department, ordered by a physician, and billed by a hospital, or 2) for renal dialysis, when furnished and billed by a freestanding ambulatory facility (see Facilities and Other Providers), are as follows:

**Diagnostic services**

- X-ray (*e.g.*, Magnetic Resonance Imagings-MRIs), laboratory, and pathological services, and machine diagnostic tests

**Preventive services**

- In **Member** and **Non-member** facilities, each cervical cancer screening, mammogram for breast cancer screening, fecal occult blood test for colorectal cancer screening, PSA (Prostate Specific Antigen) test for prostate cancer screening, tetanus-diphtheria (Td) booster, and immunization for influenza and pneumonia is paid as described above. These services are covered differently when you use Preferred providers. See page 29, Additional Benefits, for the payment levels for Preferred facility care. See page 29 also for the screening schedules related to these tests and immunizations for all providers.

**Other outpatient services**

- Radiation therapy, chemotherapy, and renal dialysis (chemotherapy and/or radiation therapy when supported by allogeneic or autologous bone marrow transplants or autologous stem cell support is covered only for those covered conditions as described under Organ/tissue transplants under Surgical Benefits on page 19)
- Physical, occupational, and speech therapy (for visit limitations, see page 28)
- Allergy tests, surveys, and injections, blood (as described under Miscellaneous services on page 27), and prescription drugs, billed for by the facility
- Hospital services in connection with dental procedures only when a nondental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient

### Outpatient surgery

**Facility care benefits**

The Plan provides coverage at the benefit levels indicated below, not subject to the calendar year deductible, for the outpatient surgical services listed on the next page when billed for by a facility:

| | High Option | Standard Option |
|---|---|---|
| | Plan pays **in full**, subject to the following copayments: | Plan pays **in full**, subject to the following copayments: |
| PPO/Preferred facilities | You pay $10 | You pay $25 |
| Member facilities | You pay $50 | You pay $100 |
| Non-member facilities | You pay $100 | You pay $150 |

# Other Medical Benefits *continued*

**Facility care benefits** *continued*

These copayments will be applied per facility per day, not per service. You will be responsible for the lesser of the stated copayments or the Billed charge(s). If Preferred or Member facilities are available, and utilized, you will be responsible for the lesser of the stated copayments, the Billed charge(s), or the Preferred or Member rate at the time your claim is processed.

**Overseas care—**The Plan pays **in full** for outpatient surgical services at hospitals located outside the U.S. or Puerto Rico.

Covered facility-billed services are noted below:

- Surgical services and related other hospital services
- Related X-ray (*e.g.*, Magnetic Resonance Imagings-MRIs), laboratory, and pathological services, and machine diagnostic tests within one business day of the covered surgical services
- Facility supplies for hemophilia home care

**Physician care**

Except as noted, the Plan provides coverage at the benefit levels indicated below for services provided, or ordered, and billed by a physician:

| | **High Option** | **Standard Option** |
|---|---|---|
| PPO/Preferred physicians | After you pay the $150 calendar year deductible, Plan pays **95% PPA** | After you pay the $200 calendar year deductible, Plan pays **95% PPA** |
| Participating physicians | After you pay the $150 calendar year deductible, Plan pays **80% PAR** | After you pay the $200 calendar year deductible, Plan pays **75% PAR** |
| Non-participating physicians | After you pay the $150 calendar year deductible, Plan pays **80% NPA**. The member is responsible for the difference between the Plan's payment and the physician's actual charge | After you pay the $200 calendar year deductible, Plan pays **75% NPA**. The member is responsible for the difference between the Plan's payment and the physician's actual charge |

See Definitions for an explanation of: Preferred, Participating, and Non-participating physicians, and PPA, PAR, and NPA under Covered charges.

**Home and office visits**

When you use Preferred physicians, home and office visits, physicians' outpatient consultations, and second surgical opinions are paid **in full** under **High** and **Standard Options** after a $10 copayment for each outpatient office visit charge. These services are paid as described above when rendered by Participating and Non-participating physicians.

**Diagnostic services**

- X-ray (*e.g.*, Magnetic Resonance Imagings-MRIs), laboratory, and pathological services, and machine diagnostic tests, including mammograms and Pap smears
- Laboratory and pathological services billed by an independent laboratory

**Preventive services**

The following routine (screening) procedures: cervical cancer screening, mammogram for breast cancer screening, fecal occult blood test for colorectal cancer screening, PSA (Prostate Specific Antigen) test for prostate cancer screening, tetanus-diphtheria (Td) booster, and immunizations for influenza and pneumonia are paid as described above when performed by **Participating** and **Non-participating** providers. These services are covered differently when you use Preferred providers, and the visit charge associated with these services is covered only with Preferred providers; see Additional Benefits, page 29. Also see page 29 for the schedules applicable to these routine (screening) services and immunizations.

**Other outpatient services**

- Radiation therapy, chemotherapy, and renal dialysis (chemotherapy and/or radiation therapy when supported by allogeneic or autologous bone marrow transplants or autologous stem cell support is covered only for those covered conditions as described under Organ/tissue transplants under Surgical Benefits on page 19)
- Outpatient physical, occupational, and speech therapy (for visit limitations, see page 28)
- Allergy tests, surveys, and injections, blood as described on page 27, and prescription drugs
- Under **High Option**, physician home visits when receiving covered home health care (see page 30)

# Other Medical Benefits *continued*

## Other services

Except as noted, benefits for the following services are paid as follows:

| High Option | Standard Option |
|---|---|
| After you pay the $150 calendar year deductible, Plan pays **80%** of the **Allowable charge** (see Definitions) | After you pay the $200 calendar year deductible, Plan pays **75%** of the **Allowable charge** (see Definitions) |

**Note**: Preferred and Participating providers may not be available for the following services in your area. When they are available, and utilized, the Plan pays benefits as shown under **Physician care** on page 26.

## Ambulance

Professional ambulance transport services associated with covered hospital inpatient care, when related to and within 72 hours after an accidental injury or medical emergency, or during covered home health care.

## Dental care for accidental injury

Services, supplies, or appliances for prompt dental care to sound natural teeth (see Definitions) required as a result of, and directly related to, an accidental injury (see Definitions) occurring while the member was covered by an FEHB plan.

## Durable medical equipment

- Rental by the member or, at the Carrier's option, purchase, if it will be less expensive, of durable medical equipment (such as respirators and home dialysis equipment) including replacement, repair, and adjustment of purchased equipment
- Wheelchairs, hospital beds, crutches, and other items determined by the Carrier to be durable medical equipment
- Orthopedic braces and prosthetic appliances (such as artificial legs and pacemakers) including replacement, repair, and adjustment
- One bra, per person per calendar year, designed for use with an external breast prosthesis

## Home nursing care

Care by a registered nurse (R.N.) or licensed practical nurse (L.P.N.), when the care is ordered by a physician. Home nursing care is available for two (2) hours per day up to **50 visits** per calendar year under **High Option** and **25 visits** per calendar year under **Standard Option**. The number of visits for which you receive reimbursement will be reduced if these services are used to meet part or all of your calendar year deductible.

## Miscellaneous services

- Allergy tests, surveys, and injections
- Blood and blood plasma except when donated or replaced, and blood plasma expanders
- Neurological testing when rendered and billed by a qualified clinical psychologist
- One set of eyeglasses or contact lenses, or one replacement to an existing prescription, required as a result of, and directly related to, a single instance of intra-ocular surgery or a single ocular injury. This benefit also applies when, in situations as described above, the condition can be corrected by surgery, but surgery is precluded (*i.e.*, cannot be performed because of age or medical complications), and lenses are prescribed in lieu of surgery
- Ostomy and catheter supplies
- Oxygen
- Medical foods for children with inborn errors of amino acid metabolism
- Prescription drugs not billed by a retail pharmacy (excludes those drugs obtained through the Mail Service Prescription Drug Program)
- Home infusion therapy
- Nonsurgical treatment for amblyopia and strabismus, for children age two through age six

### Physical, occupational, and speech therapy

Physical, occupational, and speech therapy when rendered and billed by a physical, occupational, or speech therapist who is licensed or meets the requirements of the Carrier, by a physician rendered on an outpatient basis, or by an outpatient facility. The following limits apply to outpatient care:

- Physical therapy: **75 visits** under **High Option** and **50 visits** under **Standard Option** per person per calendar year
- Occupational and speech therapy: **25 visits** under **High** and **Standard Options** per person per calendar year

The number of visits for which you receive reimbursement will be reduced if these services are used to meet part or all of your calendar year deductible.

See page 16 for physical, occupational, and speech therapy provided by a physician on an inpatient basis. See pages 25 and 26 for payment levels for outpatient physical, occupational, and speech therapy provided by a physician or outpatient facility.

## Limited benefits

### Smoking cessation benefit

After satisfaction of the calendar year deductible, under **High** and **Standard Options**, the Plan will pay **100%** of Billed charges up to a maximum payment of $100 for enrollment in one smoking cessation program per member per lifetime. Services may be rendered by any covered provider or by a smoking cessation clinic.

See pages 32 and 33, Prescription Drug Benefits, for coverage of smoking cessation drugs.

## What is not covered

- Exercise and bathroom equipment
- Lifts, such as seat, chair, or van lifts
- Air conditioners, humidifiers, dehumidifiers, and purifiers
- Shoes or related corrective devices
- Wigs
- Implanted bone conduction hearing aids
- Computer “story boards” or “light talkers” for communication-impaired individuals
- Maintenance or palliative physical, occupational, or speech therapy for a chronic disease or condition which does not require the technical proficiency or the skill and training of a physician or qualified physical, occupational, or speech therapist, except during acute exacerbations of the disease or condition
- Home nursing care when:
  1) Requested by, or for the convenience of, the patient or the patient’s family
  2) It consists primarily of bathing, feeding, exercising, homemaking, moving the patient, giving medication, or acting as a companion or sitter

# Additional Benefits

## Preventive services provided by Preferred providers

The Plan provides coverage for each home and office visit for a routine physical examination at the benefit levels indicated below when provided by a Preferred physician or Preferred facility:

| After you pay a $10 copayment, **High Option** pays **in full** | After you pay a $10 copayment, **Standard Option** pays **in full** |
|---|---|

### Routine physical examination

Home and office visits for routine (screening) examination, consisting of a history and risk assessment, chest X-ray, electrocardiogram (EKG), urinalysis, complete blood count (CBC), and 19-channel chemistry test, are covered for members as follows:

- Through age 64, once every three consecutive calendar years
- At age 65 or over, once every calendar year

This benefit does not apply to children eligible for Well Child Care benefits.

Additionally, the preventive (screening) tests and immunizations noted below are paid **in full** when provided by a Preferred physician or a Preferred facility on an outpatient basis, subject to the schedules indicated. If these services are rendered by a Preferred physician separately from the routine physical examination, you will be responsible for the $10 copayment for each associated office visit.

### Coronary artery disease screening

Cholesterol tests are covered for members as follows:

- Through age 64, once every three consecutive calendar years
- At age 65 or over, once every calendar year

This benefit does not apply to children eligible for Well Child Care benefits.

Preventive (screening) cholesterol tests are only covered and paid **in full** when provided by Preferred providers or any independent laboratory.

### Cancer screening and immunization schedules

The cancer screening and immunization schedules below are applicable for all providers, not only Preferred providers. See page 26, Other Medical Benefits, for payment levels for routine services provided by Participating and Non-participating physicians, and page 25, Other Medical Benefits, for payment levels for routine services provided by Member and Non-member facilities. **The visit charge associated with these services is covered only with Preferred physicians or Preferred facilities.**

### Breast cancer screening

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

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

### Cervical cancer screening

Annual coverage of one Pap smear for women of any age.

### Colorectal cancer screening

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

### Prostate cancer screening

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

### Immunizations

- For influenza and pneumonia, once every calendar year
- Tetanus-diphtheria (Td) booster, once every ten calendar years

## Well child care

For children up to age 22 under **High** and **Standard Options**, the Plan pays **100%** of the Allowable charge for the following covered routine services for well child care:

- All healthy newborn inpatient physician visits, including routine screening (inpatient or outpatient)
- Routine physical examinations, laboratory tests, immunizations, and related office visits as recommended by the American Academy of Pediatrics

## Accidental injury (outpatient care)

**High** and **Standard Options** pay **100%** of Covered charges for the following covered services and supplies in connection with, and within 72 hours after, accidental injury (see Definitions):

- Other hospital services in Preferred, Member, and Non-member hospitals, including related X-ray (*e.g.*, Magnetic Resonance Imagings-MRIs), laboratory, and pathological services, and machine diagnostic tests
- Physician services in the office or hospital outpatient department, including X-ray (*e.g.*, Magnetic Resonance Imagings-MRIs), laboratory, and pathological services and machine diagnostic tests

See Definitions for an explanation of Preferred, Participating, and Non-participating physicians, and Covered charges.

### Related benefits

The following related services are covered under Other Medical Benefits (see pages 25-28):

- Services related to accidental injury rendered more than 72 hours after the injury
- Care for accidental dental injury
- Ambulance transport services

## Home health care

### High Option

**High Option** pays **in full** for 90 days per calendar year for the covered home health care services listed below if:

1) the services rendered are billed by a home health care agency (such as the hospital or a visiting nurse association) which has a written agreement with the Local Plan to provide home health care services, and
2) prior approval is obtained from the Local Plan. If prior approval is not obtained, Other Medical Benefits will be provided as applicable.

**Note:** The member has the responsibility to make sure that the home health care provider has received prior approval from the Local Plan (see page 42 for instructions).

### What is covered

- Nursing care such as dressing changes, injections, and monitoring of vital signs
- Physical therapy
- Respiratory or inhalation therapy
- Prescription drugs
- Medical supplies which serve a specific therapeutic or diagnostic purpose
- Infusion therapy
- Other medically necessary services or supplies that would have been provided by a hospital if the member was hospitalized
- See page 26 for **High Option** coverage for physician home visits while receiving covered home health care services

### What is not covered

- Home health care services related to the treatment of mental conditions/substance abuse, for routine maternity care, for routine monitoring of a condition, for intermittent care of a stable condition, or for initial evaluation of the patient to determine whether or not home health care is appropriate
- Homemaking services, including housekeeping, preparing meals, or acting as a companion or sitter

### Standard Option

See page 27 for **Standard Option** coverage of home nursing care.

## Home hospice care

**High** and **Standard Options** pay **in full** if prior approval is obtained from the Local Plan for covered home hospice services rendered to members with a life expectancy of six months or less when billed by a home hospice care agency which is approved by the Local Plan.

**Note:** The member has the responsibility to make sure that the home hospice care provider has received prior approval from the Local Plan (see page 42 for instructions).

### What is covered

- Physician visits
- Nursing care
- Medical social services
- Physical therapy
- Services of home health aides
- Durable medical equipment rental
- Prescription drugs
- Medical supplies

### Related inpatient services

Inpatient hospice benefits are available only to a member receiving Home hospice care benefits. Benefits are provided for up to five (5) consecutive days in a hospital or a freestanding hospice inpatient facility. These covered inpatient hospice benefits are available only when inpatient services are necessary to control pain and manage the symptoms of the patient or to provide an interval of relief to the family (respite).

Each inpatient stay must be separated by at least 21 days and is paid in full under **High** and **Standard Options** with no per admission deductible when you are admitted to a Preferred hospital. Each inpatient stay in a Member or Non-member hospital is subject to a $100 per admission deductible under **High Option** and a $250 per admission deductible under **Standard Option**. (See page 15 for Inpatient Hospital Benefits.)

### What is not covered

- Homemaker or bereavement services

## Limited benefit

### Skilled nursing facilities

When Medicare Part A is primary payer (it pays first) and has made payment, **High** and **Standard Options** provide secondary benefits for the applicable Medicare Part A copayments incurred **in full** during the first through the 30th day of confinement per each benefit period, as defined by Medicare, in a qualified skilled nursing facility (see Facilities and Other Providers). If Medicare pays the first 20 days in full, Plan benefits will begin on the 21st day, when Medicare Part A copayments begin, and will end on the 30th day.

# Prescription Drug Benefits

## What is covered

You may purchase up to a 90-day supply of the following medications and supplies prescribed by a doctor from either a pharmacy or by mail:

- Drugs, vitamins and minerals, and nutritional supplements that by Federal law of the United States require a doctor's prescription for their purchase
- Insulin
- Needles and disposable syringes for the administration of covered medications
- Intrauterine devices (IUDs), Norplant, Depo-Provera, and oral contraceptives dispensed by a retail pharmacy; and oral contraceptives obtained through the Mail Service Program
- Drugs to aid smoking cessation that require a prescription by Federal law (limited to one regimen per calendar year)

You can save money by using generic drugs. By submitting your prescription (or those of family members covered by the Plan) to your retail pharmacy or the Mail Service Prescription Drug Program, you authorize them to substitute a Federally approved generic equivalent, if available, unless you or your physician specifically requests a name brand.

### What is not covered

- Medical supplies such as dressings and antiseptics
- Drugs and supplies for cosmetic purposes
- Medication that does not require a prescription under Federal law even if your doctor prescribes it or a prescription is required under your State law

## From a pharmacy

You may purchase up to a 90-day supply of covered drugs and supplies through the Retail Pharmacy Program. Call 1-800/624-5060 to locate a Preferred pharmacy in your area.

| | High Option | Standard Option |
|---|---|---|
| PPO/Preferred retail pharmacies | After you pay the $50 prescription drug deductible, Plan pays **85% PPA** | After you pay the $50 prescription drug deductible, Plan pays **80% PPA** |
| Non-preferred retail pharmacies | After you pay the $50 prescription drug deductible, Plan pays **65%** of the **Billed charge** | After you pay the $50 prescription drug deductible, Plan pays **60%** of the **Billed charge** |

You must present your Service Benefit Plan ID card at the time of purchase at a Preferred pharmacy and pay 100% of the PPA up to the $50 prescription drug deductible. After satisfaction of the $50 deductible, you are only responsible for the appropriate coinsurance at the time of purchase. All Preferred retail pharmacies will file claims for you. Preferred pharmacies will receive the payment and agree to accept 100% of the PPA as payment in full. At Non-preferred retail pharmacies, you must pay the full cost at the time of purchase and submit a claim. You are responsible for the $50 drug deductible and the applicable coinsurance based upon Billed charges (but see "If provider waives your share" on page 10). The Billed charge must be no more than the pharmacy's normal retail charge. Certain prescription drugs and supplies may require prior approval (see page 33). Any savings received by the Carrier on the cost of drugs purchased under this Plan from drug manufacturers are credited to the reserves held for this Plan.

### Waiver

**When Medicare Part B is the primary payer**, the $50 prescription drug deductible under **both options** and the 15% PPA when you use a Preferred retail pharmacy under **High Option** will be waived after you supply proof of your enrollment in Part B directly to the Plan (see page 44). If you use a Preferred retail pharmacy, you are required to pay 20% PPA under **Standard Option** (coinsurance is waived if you are confined in a nursing home). If you use a Non-preferred retail pharmacy, you are required to file a paper claim and pay 15% of the Billed charge under **High Option** and 40% of the Billed charge under **Standard Option** (reduced to 20% of the Billed charge when confined in a nursing home). The Billed charge must be no more than the pharmacy's normal retail charge.

### To claim benefits

Use a retail prescription drug claim form for prescription drugs and supplies purchased at Non-preferred retail pharmacies. You may obtain these forms by calling 1-800/624-5060. Follow the instructions on the form and mail it to the Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057.

# Prescription Drug Benefits *continued*

## By mail

If your doctor orders more than a 21-day supply of covered drugs or supplies, up to a 90-day supply, you may order your prescription or refill by mail from the Mail Service Prescription Drug Program. National Rx Services will fill your prescription. All drugs and supplies listed on the previous page are covered under this Program except for those that must be administered by physicians in a clinical setting.

You pay an $8 copayment under **High Option** and a $12 copayment under **Standard Option** for each prescription drug, supply, or refill you purchase through the Mail Service Program.

### Waiver

**When Medicare Part B is the primary payer,** and you use the Mail Service Prescription Drug Program, your copayment is waived after you supply proof of your enrollment in Part B directly to National Rx Services (see page 44).

### To claim benefits

The Plan will send you information on the Mail Service Prescription Drug Program. To use the Program:

1) Complete the initial mail order form.
2) Enclose your prescription and copayment.
3) Mail your order to National Rx Services, P.O. Box 30491, Tampa, FL 33630.
4) Allow approximately two weeks for delivery.

Alternatively, your physician may call in your initial prescription at 1-800/262-7890. You will be billed later for the copayment. After that, you may then call the same number to order your refill, and either charge your copayment to your credit card or have it billed to you later. Orders will be processed within two business days, but you should allow approximately one week for delivery.

## Prior approval

Certain prescription drugs and supplies may require prior approval before they will be covered under this Plan. Call 1-800/624-5060 to obtain an updated list of prescription drugs and supplies that require prior approval. Once prior approval has been obtained, you may take advantage of electronic claims processing at Preferred pharmacies, have claims paid for drugs and supplies purchased from Non-preferred pharmacies, or have drugs and supplies dispensed by the Mail Service Program.

### Retail Pharmacy Program

The Retail Pharmacy Program will request the medical evidence needed to make its coverage determination. Drugs and supplies that require prior approval also require 1) payment in full at time of purchase (including Preferred pharmacies) and 2) the member's submission of the expense(s) on a claim form. Preferred pharmacies will not file these expenses for you.

### Mail Service Program

National Rx Services will screen all prescription drugs prior to dispensing. If the drug or supply requires prior approval, your prescription will not be filled until prior approval has been obtained. The prescription will be returned to you along with a Prior Approval Request form and a letter explaining the program and procedures.

## Drugs from other sources

Prescription drugs and certain supplies not purchased from a retail pharmacy or through the Mail Service Program are covered at Other Medical Benefits levels when billed for by an outpatient facility or a physician (see pages 25 and 26), or Additional Benefits levels when billed for by a covered home health care agency (see page 30) or home hospice agency (see page 31). When hospitalized, drugs and supplies are covered under Inpatient Hospital Benefits (see page 16) or Maternity Benefits (see page 21).

## Purchasing drugs when you are overseas

Claims for covered prescription drugs and supplies purchased outside of the United States and Puerto Rico should be submitted on an Overseas Claim Form and sent to the Overseas Claims Section address listed on page 37. Prescription drugs requiring constant refrigeration cannot be shipped to APO/FPO boxes by the Mail Service Prescription Drug Program.

## Coordinating with other drug coverage

When you use a Preferred retail pharmacy and this Plan is the primary payer, you must call the Service Benefit Plan Retail Pharmacy Program at 1-800/624-5060 to request a statement of benefits for other coverage purposes.

# Standard Option Dental Benefits

## What is covered

The Plan will pay Billed charges, for the following services, up to the amount specified in the Schedule of Dental Allowances below. This is a complete list of covered dental benefits.

### Preferred Dental Network

The PPO now includes Preferred dentists who are available in all Local Plans in most areas. Preferred dentists agree to accept a negotiated, discount amount called the Maximum Allowable Charge (MAC) as payment in full. They will also file your dental claims for you. You are responsible, as an out-of-pocket expense, for the difference between the amount specified on this Schedule of Dental Allowances and the MAC. To find a Preferred dentist near you or to obtain a copy of the MAC listing applicable to your area, contact your Local Plan.

### Complete schedule of dental allowances

| | ADA Code | | Up to Age 13 | Age 13 and over |
|---|---|---|---|---|
| **Clinical oral evaluations** | 0120 | Periodic oral evaluation* | $ 12 | $ 8 |
| | 0140 | Limited oral evaluation | 14 | 9 |
| | 0150 | Comprehensive oral evaluation | 14 | 9 |
| | 0160 | Detailed and extensive oral evaluation | 14 | 9 |
| **Radiographs** | 0210 | Intraoral—complete series | $ 36 | $22 |
| | 0220 | Intraoral—periapical—first film | 7 | 5 |
| | 0230 | Intraoral—periapical—each additional film | 4 | 3 |
| | 0240 | Intraoral—occlusal film | 12 | 7 |
| | 0250 | Extraoral—first film | 16 | 10 |
| | 0260 | Extraoral—each additional film | 6 | 4 |
| | 0270 | Bitewing—single film | 9 | 6 |
| | 0272 | Bitewings—two films | 14 | 9 |
| | 0274 | Bitewings—four films | 19 | 12 |
| | 0290 | Posterior-anterior or lateral skull and facial bone survey film | 45 | 28 |
| | 0330 | Panoramic film | 36 | 23 |
| **Tests and laboratory exams** | 0460 | Pulp vitality tests | $ 11 | $ 7 |
| **Palliative treatment** | 9110 | Palliative (emergency) treatment of dental pain—minor procedure | $ 24 | $15 |
| | 2940 | Sedative filling | 24 | 15 |
| **Preventive** | 1120 | Prophylaxis—child* | $ 22 | $14 |
| | 1110 | Prophylaxis—adult* | — | 16 |
| | 1201 | Topical application of fluoride (including prophylaxis)—child* | 35 | 22 |
| | 1203 | Topical application of fluoride (prophylaxis not included)—child | 13 | 8 |
| | 1205 | Topical application of fluoride (including prophylaxis)—adult* | — | 24 |
| | 1204 | Topical application of fluoride (prophylaxis not included)—adult | — | 8 |
| **Space maintenance (passive appliances)** | 1510 | Space maintainer—fixed—unilateral | $ 94 | $59 |
| | 1515 | Space maintainer—fixed—bilateral | 139 | 87 |
| | 1520 | Space maintainer—removable—unilateral | 94 | 59 |
| | 1525 | Space maintainer—removable—bilateral | 139 | 87 |
| | 1550 | Recementation of space maintainer | 22 | 14 |

* Limited to two per person per calendar year

# Standard Option Dental Benefits *continued*

| | ADA Code | | Up to Age 13 | Age 13 and over |
|---|---|---|---|---|
| **Amalgam restorations (including polishing)** | 2110 | Amalgam—one surface, primary | $22 | $14 |
| | 2120 | Amalgam—two surfaces, primary | 31 | 20 |
| | 2130 | Amalgam—three surfaces, primary | 40 | 25 |
| | 2131 | Amalgam—four or more surfaces, primary | 49 | 31 |
| | 2140 | Amalgam—one surface, permanent | 25 | 16 |
| | 2150 | Amalgam—two surfaces, permanent | 37 | 23 |
| | 2160 | Amalgam—three surfaces, permanent | 50 | 31 |
| | 2161 | Amalgam—four or more surfaces, permanent | 56 | 35 |
| **Silicate restorations** | 2210 | Silicate cement—per restoration | $18 | $11 |
| **Filled or unfilled resin restorations** | 2330 | Resin—one surface, anterior | $25 | $16 |
| | 2331 | Resin—two surfaces, anterior | 37 | 23 |
| | 2332 | Resin—three surfaces, anterior | 50 | 31 |
| | 2335 | Resin—four or more surfaces or involving incisal angle (anterior) | 56 | 35 |
| | 2380 | Resin—one surface, posterior-primary | 22 | 14 |
| | 2381 | Resin—two surfaces, posterior-primary | 31 | 20 |
| | 2382 | Resin—three or more surfaces, posterior-primary | 40 | 25 |
| | 2385 | Resin—one surface, posterior-permanent | 25 | 16 |
| | 2386 | Resin—two surfaces, posterior-permanent | 37 | 23 |
| | 2387 | Resin—three or more surfaces, posterior-permanent | 50 | 31 |
| **Inlay restorations** | 2510 | Inlay—metallic—one surface | $25 | $16 |
| | 2520 | Inlay—metallic—two surfaces | 37 | 23 |
| | 2530 | Inlay—metallic—three or more surfaces | 50 | 31 |
| | 2610 | Inlay—porcelain/ceramic—one surface | 25 | 16 |
| | 2620 | Inlay—porcelain/ceramic—two surfaces | 37 | 23 |
| | 2630 | Inlay—porcelain/ceramic—three or more surfaces | 50 | 31 |
| | 2650 | Inlay—composite/resin—one surface | 25 | 16 |
| | 2651 | Inlay—composite/resin—two surfaces | 37 | 23 |
| | 2652 | Inlay—composite/resin—three or more surfaces | 50 | 31 |
| **Other restorative services** | 2951 | Pin retention—per tooth, in addition to restoration | $13 | $ 8 |
| **Extractions—includes local anesthesia and routine post-operative care** | 7110 | Single tooth | $30 | $19 |
| | 7120 | Each additional tooth | 27 | 17 |
| | 7130 | Root removal—exposed roots | 71 | 45 |
| **Surgical extractions—includes local anesthesia and routine post-operative care** | 7210 | Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth | $43 | $27 |
| | 7250 | Surgical removal of residual tooth roots (cutting procedure) | 71 | 45 |
| **Anesthesia** | 9220 | General anesthesia in connection with covered extractions | $43 | $27 |

## Related benefits

**Oral and maxillofacial surgery or accidental injury**

For covered oral and maxillofacial surgery or dental care related to accidental injury, see pages 20 and 27.

**Note:** Please check the Preferred status of your dentist or oral surgeon before receiving oral surgery. A Preferred dentist who accepts the MACs as payment in full for the dental services listed above may not be a Preferred provider for oral surgical procedures.

## What is not covered

Any dental procedures involving orthodontic care, dental implants, periodontal disease, or preparing the mouth for the fitting or the continued use of dentures, except as specifically described or referenced.

# How to Claim Benefits

## Claim forms and identification cards

For claim forms and other claims filing advice, contact your Local Plan. If you do not receive your identification card(s) within 60 days after the effective date of your enrollment you may contact the Local Plan serving the area in which you reside or write to: FEP Enrollment Services, 550 12th Street, SW, Washington, DC 20065-1463 to report the delay in receiving your card(s), to get replacement cards, to obtain your Plan identification number, or to obtain claim forms or other claims filing advice. Give your full name, address, date of birth, agency where employed, whether enrollment is for Self Only or Self and Family, whether **High** or **Standard Option**, and identification ("R") number, if known. In the meantime, use your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM as proof of enrollment when you obtain services.

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

## How to file claims

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

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

In addition:

- A copy of the explanation of benefits (EOB) from any primary payer (such as Medicare) must be sent with your claim.
- Bills for private duty nurses must show that the nurse is a registered or licensed practical nurse.
- Claims for rental or purchase of durable medical equipment, private duty nursing, and physical, occupational and speech therapy require a written statement from the doctor specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and supplies that are not ordered through the Mail Service Prescription Drug Program must include receipts that include the prescription number, name of drug or supply, prescribing physician's name, date, and charge.
- Claims for overseas (foreign) services should include an English translation. Charges should be converted to U.S. dollars using the exchange rate applicable at the time the expense was incurred.

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

Contact your Local Plan for information on where to submit claims.

### Records

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

### Submit claims promptly

All claims must be submitted no later than December 31 of the calendar year after the one in which the covered care or service was provided, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Use a separate claim form for each family member. These procedures include prescription drugs that are not obtained from a retail pharmacy. See page 37 for a description of how to claim benefits for retail pharmacy-obtained prescription drugs. When covered expenses exceed the deductible, complete a claim form, attach itemized bills, and send them to the Local Plan serving the area where the services were rendered. For services other than inpatient, you may send the claim to the Local Plan serving the area where you reside. (See page 39 for the offices which process claims and maintain records.) File expenses quarterly thereafter. Claims payments for covered services submitted by you are usually sent to you.

If the Local Plan returns a claim or part of a claim for additional information, it must be resubmitted within 90 days, or before the timely filing period expires, whichever is later. For long or continuing hospital stays or other long-term care, claims must be submitted at least every 30 days.

For information about prescription drugs (including insulin, insulin-related disposable syringes, and other diabetic and non-diabetic supplies) obtained through the Mail Service Prescription Drug Program, see instructions on page 33.

### Overseas claims

For covered services rendered in hospitals outside the United States and Puerto Rico and performed by physicians outside the United States, send a completed Overseas Claim Form and the itemized bills to: NCA Processing Department, 550 12th Street, SW, Washington, DC 20065-8473, Attention: FEP Overseas Claims Section. Overseas Claim Forms can be obtained from this address or your Local Plan. Any written inquiries concerning the processing of overseas claims should be sent to this address.

### Preferred and Member hospitals and facilities in the U.S. and Puerto Rico

Present your identification card when admitted or when you receive outpatient care. The hospital has the necessary forms and will submit them to the Local Plan. Benefits are paid to the hospital, which will bill you for any coinsurance, copayments, noncovered charges, or any charges applied to your calendar year deductible.

### Preferred and Participating physicians in the U.S.

Always ask if the physician is a Preferred or Participating physician for purposes of this Plan. Present your identification card and sign the necessary forms. Benefits are usually paid to the physician, who will bill you for any coinsurance, copayments, noncovered services, or any charges applied to your calendar year deductible.

### Prescription drug claims (Retail Pharmacy Program)

When you use Preferred retail pharmacies, show your Service Benefit Plan ID card. After you have satisfied the $50 drug deductible, you pay the applicable coinsurance for your prescription drug. Preferred retail pharmacies will file your prescription drug claim for you. Reimbursement for covered drugs will be sent to pharmacies. Members who do not have a valid Service Benefit Plan ID card, who do not show their card at the time of purchase, or who failed to receive prior approval when required will have to file a paper claim form to obtain benefits for drugs purchased at Preferred pharmacies.

For Non-preferred retail pharmacy expenses, you should use a retail prescription drug claim form to claim benefits for retail pharmacy-obtained prescription drugs. Prescription drug claim forms may be obtained from Local Plans, or by calling 1-800/624-5060. Hearing-impaired members with TDD equipment can call 1-800/624-5077. Follow the instructions on the claim form and submit the completed form to:

Service Benefit Plan Retail Pharmacy Program
P.O. Box 52057
Phoenix, AZ 85072-2057

## When more information is needed

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

## Confidentiality

Medical and other information provided to the Carrier, including claim files, is kept confidential and will be used only: 1) by the Carrier and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education.

## Disputed claims review

### Reconsideration

If a claim for payment is denied by the Carrier, you must ask the Carrier, in writing and within six months of the date of the denial, to reconsider its decision before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Carrier an opportunity to reconsider your claim. Before you ask the Carrier to reconsider, you should first check with your provider or facility to be sure that the claim was filed correctly. For instance, did they use the correct procedure code for the service(s) performed (surgery, laboratory test, X-ray, office visit, etc.)? Indicate any complications of any surgical procedure(s) performed. Include copies of an operative or procedure report, or other documentation that supports your claim. Your written request to the Carrier must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment should have been paid.

## Reconsideration
*continued*

Within 30 days after receipt of your request for reconsideration, the Carrier must affirm the denial in writing to you, pay the claim, or request additional information that is reasonably necessary to make a determination. If the Carrier asks a provider for information it will send you a copy of this request at the same time. The Carrier has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Carrier will base its decision on the information it has on hand.

## OPM review

If the Carrier affirms its denial, you have the right to request a review by OPM to determine whether the Carrier's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Carrier's letter affirming its initial denial.

You may also ask OPM for a review if the Carrier fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Carrier. In this case, OPM must receive a request for review within 120 days of your request to the Carrier for reconsideration or of the date you were notified that the Carrier needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the Carrier should have paid the denied claim. If the Carrier has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Carrier requesting reconsideration;
- A copy of the Carrier's reconsideration decision (if the Carrier failed to respond, provide instead (a) the date of your request to the Carrier, or (b) the dates the Carrier requested and you provided additional information to the Carrier);
- Copies of documents that support your claim (such as doctors' letters, operative reports, bills, medical records, explanation of benefit (EOB) forms); and
- Your daytime phone number.

Medical documentation received from you or the Carrier during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division 1, P.O. Box 436, Washington, DC 20044.

You (or a person acting on your behalf ) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies, or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 809.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Carrier's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Carrier's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

**Privacy Act statement**—If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Carrier to determine if the Carrier has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Carrier in support of OPM's decision on the disputed claim.

## Blue Cross and Blue Shield offices

You can get information, claim forms, and assistance from any Local Plan office listed below.

Offices in the cities printed in bold face also process claims and maintain records. Consult the local telephone directory for street addresses and telephone numbers.

**Alabama: Birmingham**, Florence, Huntsville, Mobile, Montgomery, Tuscaloosa
**Alaska:** Anchorage, **Seattle (WA)**
**Arizona:** Flagstaff, **Phoenix**, Sun City, Tempe, Tucson
**Arkansas:** El Dorado, Fayetteville, Fort Smith, Hot Springs, Jonesboro, **Little Rock,** Pine Bluff, Texarkana
**California:** Los Angeles, Oakland, **Red Bluff,** San Francisco, **Woodland Hills**
**Colorado: Denver**
**Connecticut: North Haven**
**Delaware: Wilmington**
**District of Columbia: Washington, DC**
**Florida:** Fort Lauderdale, Fort Myers, Gainesville, **Jacksonville,** Lakeland, Miami, Orlando, Panama City, Pensacola, Sarasota, Tallahassee, Tampa, West Palm Beach
**Georgia:** Albany, Athens, Atlanta, Augusta, Brunswick, Cartersville, **Columbus,** Dalton, Dublin, Gainesville, Griffin, Macon, Savannah, Valdosta
**Hawaii:** Hilo, **Honolulu,** Kahului, Kailua-Kona, Lihue
**Idaho: Boise,** Coeur d'Alene, Idaho Falls, **Lewiston,** Pocatello, Twin Falls
**Illinois:** Champaign, Chicago, Danville, Jacksonville, Oakbrook, **Quincy,** Rockford, Springfield
**Indiana: Indianapolis**
**Iowa:** Ames, Burlington, Cedar Rapids, Council Bluffs, Davenport, **Des Moines,** Dubuque, Iowa City, Mason City, Newton, Ottumwa, Red Oak, Sioux City, Waterloo
**Kansas:** Dodge City, Garden City, Hays, Hutchinson, Independence, Lawrence, Manhattan, Pittsburg, Salina, **Topeka,** Wichita
**Kentucky:** Louisville
**Louisiana: Baton Rouge**
**Maine:** Augusta, Bangor, Presque Isle, **South Portland**
**Maryland:** Annapolis, Cumberland, Easton, Frederick, Hagerstown, **Owings Mills,** Salisbury
**Massachusetts: Rockland**
**Michigan:** Alpena, **Detroit,** Flint, Grand Rapids, Jackson, Kalamazoo, Lansing, Marquette, Mount Pleasant, Muskegon, Port Huron, Saginaw, Traverse City, Utica
**Minnesota:** Duluth, Fergus Falls, Mankato, Marshall, Moorhead, Rochester, St. Cloud, **St. Paul,** Willmar, Winona
**Mississippi:** Biloxi, Columbus, Hattiesburg, **Jackson**
**Missouri:** Cape Girardeau, **Kansas City, St. Louis,** Springfield
**Montana:** Billings, Bozeman, Butte, **Great Falls, Helena,** Kalispell, Missoula
**Nebraska:** Grand Island, Lincoln, **Omaha**
**Nevada:** Las Vegas, **Reno**
**New Hampshire: Manchester**
**New Jersey: Newark**
**New Mexico: Albuquerque**
**New York: Albany,** Binghamton, **Buffalo**, Eastchester, Elmira, Jamestown, New York City, **Rochester, Syracuse, Utica/ Watertown**
**North Carolina:** Asheville, **Chapel Hill,** Charlotte, Elizabeth City, Fayetteville, Greensboro, Greenville, Hickory, Raleigh, Wilmington
**North Dakota:** Bismarck, Devils Lake, Dickinson, **Fargo,** Grand Forks, Jamestown, Minot, Williston
**Ohio: Cincinnati, Cleveland**
**Oklahoma:** Lawton, Oklahoma City, **Tulsa**
**Oregon:** Bend, Coos Bay/North Bend, Eugene, Medford, Pendleton, **Portland,** Roseburg, Salem
**Pennsylvania:** Allentown, **Camp Hill, Harrisburg, Philadelphia, Pittsburgh, Wilkes-Barre**
**Puerto Rico:** Hato Rey, **San Juan**
**Rhode Island: Providence**
**South Carolina: Charleston, Columbia**
**South Dakota:** Rapid City, **Sioux Falls**
**Tennessee: Chattanooga,** Jackson, Kingsport, Knoxville, Nashville, Memphis
**Texas:** Abilene, Amarillo, Austin, Beaumont, Corpus Christi, **Dallas,** Fort Worth, Harlingen, Houston, Lubbock, Midland, San Antonio, Tyler, Waco
**Utah: Ogden,** Provo, Salt Lake City, St. George
**Vermont: Berlin,** Rutland, South Burlington, Springfield
**Virginia:** Richmond, **Roanoke**
**Washington: Seattle, Spokane, Tacoma**
**West Virginia:** Charleston, Martinsburg, **Parkersburg,** Wheeling
**Wisconsin: Milwaukee**
**Wyoming:** Casper, **Cheyenne,** Cody, Gillette, Jackson, Laramie, Rawlins, Riverton, Rock Springs, Sheridan, Worland

# Protection Against Catastrophic Costs

## Catastrophic protection

For services with coinsurance or copayments (other than those shown below as excluded from this Catastrophic Protection Benefit), the Plan pays **100%** of its Covered charges for the remainder of the calendar year if out-of-pocket expenses for certain coinsurance, copayments, the calendar year deductible, prescription drug deductible, and per admission deductibles in that calendar year exceed $2,700 (**High Option**) or $3,750 (**Standard Option**) for you and any covered family members.

### Preferred providers

When your eligible out-of-pocket expenses, as discussed above, from using Preferred providers (when the services are eligible to be received from Preferred providers) exceed $1,000 (**High Option**) or $2,000 (**Standard Option**), the Plan pays **100%** of its Covered charges for covered expenses when you continue to select Preferred providers for the remainder of the calendar year. Whether or not you use Preferred providers, your share of out-of-pocket expenses will not exceed $2,700 (**High Option**) or $3,750 (**Standard Option**) in a calendar year.

### Out-of-pocket expenses

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

- The calendar year deductible of $150 (**High Option**) or $200 (**Standard Option**) and the $50 prescription drug deductible under **both options**;
- The per admission deductible of $100 (**High Option**) or $250 (**Standard Option**) you pay for inpatient Non-preferred hospital care;
- The $10 (**High Option**) and $25 (**Standard Option**) copayments that you pay for outpatient facility care and outpatient facility surgical care in Preferred facilities under Other Medical Benefits;
- The $50 (**High Option**) and $100 (**Standard Option**) copayments that you pay for outpatient facility care and outpatient facility surgical care in Member facilities under Other Medical Benefits;
- The 5% PPA coinsurance (**both options**) you pay for care provided by Preferred physicians, the 20% PAR (**High Option**) and 25% PAR (**Standard Option**) coinsurance you pay for care provided by Participating physicians, and the 20% NPA (**High Option**) and 25% NPA (**Standard Option**) coinsurance you pay for care provided by Non-participating physicians and other covered professionals under Inpatient Hospital Benefits, Surgical Benefits, Maternity Benefits, and Other Medical Benefits;
- The $10 copayment (**both options**) that you pay for each home and office visit, physician's outpatient consultation, and second surgical opinion when provided by a Preferred physician under Other Medical Benefits, Physician care, or each preventive (screening) physical examination when provided by a Preferred physician or Preferred facility under Additional Benefits, Preventive services provided by Preferred providers; and
- The 15% PPA (**High Option**) and 20% PPA (**Standard Option**) coinsurance you pay for pharmacy-obtained drugs when provided by a Preferred pharmacy, and 35% of Billed charges (**High Option**) and 40% of Billed charges (**Standard Option**) coinsurance you pay for pharmacy-obtained drugs when provided by a Non-preferred pharmacy under Prescription Drug Benefits.

The following expenses are not included under this Catastrophic Protection Benefit. They are not counted toward eligible out-of-pocket expenses and are not payable by the Plan when the Catastrophic Protection Benefit out-of-pocket limits have been reached:

- Expenses in excess of Allowable charges or maximum benefit limitations;
- Mail Service Prescription Drug Program copayments;
- The 30% of the Non-member rate coinsurance you pay for Non-member inpatient facility care;
- The $100 (**High Option**) and $150 (**Standard Option**) copayments you pay for Non-member outpatient facility care;
- Expenses for Mental Conditions/Substance Abuse Benefits or Dental Benefits; and
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see pages 5, 41, and 42).

# Protection Against Catastrophic Costs *continued*

**Carryover**

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

## *Other Information*

# Precertification

### Precertify before admission

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

### To precertify a scheduled admission:

- You, your representative, your physician, or your hospital must call the Local Plan prior to admission.
- Provide the following information: enrollee's name and Service Benefit Plan identification number; patient's name, birth date, and phone number; reason for hospitalization, proposed treatment, or surgery; name of hospital or facility; name and phone number of admitting physician; and number of planned days of confinement.

The Local Plan will then tell the physician and/or hospital the number of approved days of confinement for the care of the patient's condition. Written confirmation of the certification decision will be sent to you, your physician, and the hospital. If the length of stay needs to be extended, follow the procedures below.

### Need additional days?

If any additional days are required, your physician or the hospital must request certification for the additional days. If the admission is precertified but you remain confined beyond the number of days certified as medically necessary, the Plan will not pay for charges incurred on any extra days that are determined to not be medically necessary by the Carrier during the claim review.

### You don't need to precertify an admission when:

- Medicare Part A, or another group health insurance policy, is the primary payer for the hospital confinement (see page 43). Precertification is required, however, when Medicare hospital benefits are exhausted prior to using lifetime reserve days.
- You are confined in a hospital outside the United States.

### Emergency admissions

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

## Maternity admissions

Precertification is **not** required for maternity admissions for routine deliveries. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 72 hours after a cesarean section, your physician or the hospital must contact the Local Plan for certification of additional days. The Plan will not pay for charges incurred on any extra days that have not been certified. Certification for additional days must also be requested for a covered newborn confined beyond the mother's discharge date.

## Other considerations

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

## If you do not precertify

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

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

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

## Prior approval

Before the following services are rendered, you or your provider should contact 1) the Local Plan where the services will be rendered, 2) the Retail Pharmacy Program for certain drugs and supplies, or 3) the Carrier for the clinical trials benefit for certain organ/tissue transplant procedures, for information and procedures for prior approval.

- **Home health care (High Option)—**The Local Plan will request the medical evidence it needs to make its coverage determination (see page 30).
- **Home hospice care—**The Local Plan will request the medical evidence it needs to make its coverage determination (see page 31).
- **Organ/tissue transplants—**The Local Plan will request the medical evidence it needs to make its coverage determination. The Local Plan will consider whether the facility is approved for the procedure and whether the patient meets the facility's criteria (see page 19).
- **Clinical trials for certain organ/tissue transplants—**The Carrier will request the records it needs to make its coverage determination. Inquiries and prior approval requests should be directed to the Clinical Trials Information Unit of the Blue Cross and Blue Shield Association at 1-800/225-2268 (see page 19). This number is for prior approval of clinical trials for bone marrow and stem cell transplants for multiple myeloma, breast cancer, and epithelial ovarian cancer only.
- **Prescription drugs and supplies—**The Retail Pharmacy Program will request the medical evidence it needs to make its coverage determination. Drugs and supplies that require prior approval also require 1) payment in full at time of purchase (including Preferred pharmacies) and 2) the member's submission of the expense(s) on a claim form. Preferred pharmacies will not file these expenses for you.

# This Plan and Medicare

## Coordinating benefits

The following information applies only to enrollees and covered family members who are entitled to benefits from both this Plan and Medicare. You must disclose information about Medicare coverage, including your enrollment in a Medicare prepaid plan, to this Carrier; this applies whether or not you file a claim under Medicare. You must also give this Carrier authorization to obtain information about benefits or services denied or paid by Medicare when they request it. It is also important that you inform the Carrier about other coverage you may have as this coverage may affect the primary/secondary status of this Plan and Medicare (see pages 11-13).

This Plan covers most of the same kinds of expenses as Medicare Part A, hospital insurance, except that primary benefits are not available from this Plan for qualified skilled nursing facility care, and Part B, medical insurance, except that Medicare does not cover prescription drugs.

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

## This Plan is primary if:

1) You are age 65 or over, have Medicare Part A (or Parts A and B), and are employed by the Federal Government;
2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are employed by the Federal Government;
3) The patient (you or a covered family member) is within the first 18 months of eligibility to receive Medicare Part A benefits due to End Stage Renal Disease (ESRD), except when Medicare was the patient's primary payer on the day before he or she became eligible for Medicare Part A due to ESRD; or
4) The patient (you or a covered family member) is under age 65 and eligible for Medicare solely on the basis of disability, and you are employed by the Federal Government.

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

## Medicare is primary if:

1) You are an annuitant age 65 or over, covered by Medicare Part A (or Parts A and B) and are not employed by the Federal Government;
2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are not employed by the Federal Government;
3) You are age 65 or over and (a) you are a Federal judge who retired under title 28, U.S.C., (b) you are a Tax Court judge who retired under Section 7447 of title 26, U.S.C., or (c) you are the covered spouse of a retired judge described in (a) or (b);
4) You are an annuitant not employed by the Federal Government, and either you or a covered family member (who may or may not be employed by the Federal Government) is under age 65 and eligible for Medicare on the basis of disability;
5) You are enrolled in Part B only, regardless of your employment status;
6) You are age 65 or over and employed by the Federal Government in an appointment that excludes similarly appointed nonretired employees from FEHB coverage, and have Medicare Part A (or Parts A and B);
7) You are a former Federal employee receiving workers' compensation and the Office of Workers Compensation has determined that you are unable to return to duty;
8) The patient (you or a covered family member) has completed the 18-month ESRD coordination period and is still eligible for Medicare due to ESRD; or
9) The patient (you or a covered family member) becomes eligible for Medicare due to ESRD after Medicare assumed primary payer status for the patient under rules 1) through 7) above.

## When Medicare is primary

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

**Inpatient Hospital Benefits:** If you are enrolled in Medicare Part A and Medicare is the primary payer, the Plan will waive the per admission deductible applicable in Member and Non-member hospitals and the Non-member hospital coinsurance. The requirement to precertify each hospital admission is also waived. The Plan will not waive the difference between the Average charge and the Billed charge (see page 49) at a Non-member hospital once Medicare benefits have been exhausted. If you are enrolled in Medicare Part B and Medicare is the primary payer, the Plan will waive the calendar year deductible and any coinsurance for inhospital physician care.

## When Medicare is primary *continued*

**Surgical Benefits and Other Medical Benefits:** If you are enrolled in Medicare Part B and Medicare is the primary payer, the Plan will waive the calendar year deductible, any coinsurance or outpatient facility copayments, and the $10 copayment for each home and office visit, physician outpatient consultation, and second surgical opinion. The Preferred, Member, and Non-member facility copayments for outpatient surgery are also waived.

**Maternity Benefits:** Deductibles, copayments, and coinsurance are waived the same as for Inpatient Hospital Benefits, Surgical Benefits, and Other Medical Benefits.

**Mental Conditions/Substance Abuse Benefits:** If you are enrolled in Medicare Part A and Medicare is the primary payer, the Plan will waive the inpatient hospital mental conditions/ substance abuse per day copayments. If you are enrolled in Medicare Part B and Medicare is the primary payer, the Plan will waive the inpatient and outpatient professional care coinsurance, outpatient facility care copayments, and the calendar year deductible. Benefit limits will not be waived.

**Additional Benefits:** If you are enrolled in Medicare Part B and Medicare is the primary payer, the $10 copayment for each preventive (screening) physical examination provided by a Preferred physician or facility is waived.

**Prescription Drug Benefits:** If you are enrolled in Medicare Part B and Medicare is the primary payer, the Plan will waive the prescription drug deductible and the Mail Service Prescription Drug Program per prescription copayments. If you are enrolled in **High Option**, the Plan will also waive the 15% PPA coinsurance if you use a Preferred pharmacy, and reduce your coinsurance to 15% of the Billed charge if you use a Non-preferred pharmacy.

When Medicare is the primary payer, this Plan will pay the lesser of 1) its benefits in full, or 2) a reduced amount that, when added to the benefits payable by Medicare, will not exceed either the actual charge for the service or 100% of the Covered charge for the service, whichever is less, or, for physician services, the amount specified by Medicare as described below.

## When you also enroll in a Medicare prepaid plan

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

## Medicare's payment and this Plan

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

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

Non-Medicare-participating doctors do not need to accept assignment. When they do not accept assignment on a claim, they can bill you for more than the Medicare-approved amount—up to a limit set by the Medicare law (the Social Security Act, 42 U.S.C.) called the limiting charge. The limiting charge is 115 percent of the Medicare approved amount. If you use a doctor who does not accept assignment for the claim, the doctor is permitted to bill you after the Plan has paid only if the Medicare and Plan payments combined do not total the limiting charge set by the Medicare law for non-Medicare-participating doctors. Neither you nor your FEHB Plan is liable for any amount in excess of the Medicare limiting charge for charges of a non-participating Medicare doctor. The Medicare Explanation of Benefits (EOB) form will have more information about this limit.

## How to claim benefits

In most cases, when services are covered by both Medicare and this Plan, Medicare is the primary payer if you are an annuitant and this Plan is the primary payer if you are an employee. When Medicare is the primary payer, your claims should first be submitted to Medicare. To be sure your claims are processed by this Carrier, you must submit the EOB form from Medicare and duplicates of all bills along with a completed claim form. The Carrier will not process your claim without knowing whether you have Medicare and, if you do, without receiving the Medicare EOB.

## How to claim benefits
*continued*

Claims should show both your Service Benefit Plan identification number (8 digits preceded by "R") and your Medicare identification number which is on your Medicare card. Claims for benefits which are not covered by Medicare should be sent directly to your Local Plan. See page 37 for information on how retail pharmacy-obtained drug expenses are filed.

# Enrollment Information

## If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Carrier. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Carrier. See "How to claim benefits" on page 36.

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

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system (see "Effective date" on page 50). Coverage under your new plan for a hospitalized member may be delayed if you are currently enrolled in another FEHB plan and you or a covered family member are hospitalized on the effective date of your enrollment; see "If you are hospitalized" below.

No FEHB plan may refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program except as stated in any cosmetic surgery or dental benefits description in this brochure.

### If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

## Your responsibility

**It is your responsibility to be informed about your health benefits.** Your employing office or retirement system can provide information about when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures, and other materials you need to make an informed decision.

## Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in this Plan. If you changed plans or plan options, see "If you are a new member" above. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.

## Things to keep in mind *continued*

- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period.
- You will not be informed by your employing office (or your retirement system) or your Carrier when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Carrier does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions (including divorces) of covered family members to the Carrier promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

  Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. **Before** you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

  You may also remain enrolled in this Plan when you join a Medicare prepaid plan. See page 44 for how this Plan's benefits are affected when you are enrolled in a Medicare prepaid plan.

  Contact your local Social Security Administration (SSA) office for information on local Medicare plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.
- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

## Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she will generally be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

### Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

### Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

## Temporary continuation of coverage (TCC)
*continued*

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date, and coverage may not exceed the 18- or 36-month period noted above.

## Notification and election requirements

- **Separating employees—**Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.
- **Children—**You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.
- **Former spouses—**You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

  The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

## Conversion to individual coverage

When none of the above choices is available—or chosen—when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, *e.g.*, divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

# Definitions

**Accidental injury**

An injury caused by an external force or element such as a blow or fall and which requires immediate medical attention, including animal bites and poisonings.

Dental care for accidental injury is limited to dental treatment necessary to repair sound natural teeth. Injury to the teeth while eating is not considered an accidental injury.

**Admission**

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

**Allowable charge**

See Covered charges.

**Anesthesia service**

The administration by injection or inhalation of a drug or other anesthetic agent (including acupuncture) to obtain muscular relaxation, loss of sensation, or loss of consciousness.

**Assignment**

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

**Average charge**

See Covered charges.

**Billed charge**

See Covered charges.

**Calendar year**

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

**Carrier**

The Blue Cross and Blue Shield Association, on behalf of local Blue Cross and Blue Shield Plans.

**Collateral visit**

A session to confirm the patient's diagnosis and establish a treatment plan and, during the course of treatment, to evaluate the patient's response to treatment.

**Concurrent care**

Hospital inpatient care by a physician other than the attending physician 1) for a condition not related to the primary diagnosis, or 2) because the medical complexity of the patient's condition requires additional medical care.

**Congenital anomaly**

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

**Cosmetic surgery**

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

## Covered charges

Charges for covered services. The following are considered Covered charges:

- **Allowable charge—**There are three types of Allowable charges: the Preferred Provider Allowance (PPA), which applies to charges from Preferred professionals and pharmacies; the Participating Provider Allowance (PAR), which applies to charges from Participating professional providers; and the Non-participating Provider Allowance (NPA), which applies to charges from Non-participating professional providers. If you are age 65 or older and not enrolled in Medicare, this may not apply (see page 13). The definition of each Allowable charge is:
  - **Preferred Provider Allowance (PPA)—**A negotiated allowance most Preferred professionals and pharmacies agree to accept as payment in full, when the Plan pays primary benefits. (See pages 7-8 for information about Preferred physicians and acceptance of the Preferred Provider Allowance in your Local Plan area.)
  - **Participating Provider Allowance (PAR)—**A negotiated allowance most Participating professionals agree to accept as payment in full, when the Plan pays primary benefits. (See pages 7-8 for information about Participating physicians and acceptance of the Participating Provider Allowance in your Local Plan area.)
  - **Non-participating Provider Allowance (NPA)—**An allowance equal to the greater of 1) the Medicare participating fee schedule amount for the service or supply in the geographic area in which it was performed or obtained (or 60% of the Billed charge if there is no equivalent Medicare fee schedule amount) or 2) 80% of the 1997 Usual, Customary and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained.

    **—Usual, Customary and Reasonable (UCR)—**
    **Profile**: Local Plans determine reimbursement for covered services by applying a profile. The profile is developed from the actual charges by providers in their area. The profiles are generally updated annually; however, local exceptions may apply.
    **Accepted allowance**: Local Plans may determine reimbursement for covered expenses based on an accepted allowance instead of a profile. Accepted allowances are based on what Participating providers are accepting as payment in full in the Local Plan area.

    Non-participating physicians and other Non-participating providers are under no obligation to accept the Plan's allowance as payment in full. If you use Non-participating providers, you will be responsible for the difference between the Plan's payment and the provider's charge, including any applicable copayments, coinsurance, or deductibles.
- **Average charge—**An amount established by the Local Plan for a Non-member facility, not to exceed the average semiprivate rate charged by similar institutions in the same area for inpatient care. A Non-member facility is not required to accept the Average charge as payment in full.
- **Billed charge—**Charges for covered services billed by a provider (but see "If provider waives your share" on page 10 and Prescription Drug Benefits, "From a pharmacy," on page 32). This amount may be different from the total amount submitted by the provider because it does not include charges for noncovered services.
- **Member rate—**The negotiated amount of payment that the Local Plan has agreed is due to a Member facility from the Plan and the enrollee for a claim at the time the claim is processed, including any savings the Local Plan receives from discounts that are known and that can be accurately calculated at the time the claim is processed. The Member rate may be subject to a periodic adjustment that generally, but not always, decreases the negotiated amount of payment due to the facility for the claim. If the payment is decreased, the amount of the decrease is credited to the reserves held for this Plan. If the payment is increased, the Plan pays that cost on behalf of the enrollee.
- **Non-member rate—**The Billed charge (see above) or the Average charge (see above).
- **Preferred rate—**The negotiated amount of payment that the Local Plan has agreed is due to a Preferred facility from the Plan and the enrollee for a claim at the time the claim is processed, including any savings the Local Plan receives from discounts that are known and that can be accurately calculated at the time the claim is processed. The Preferred rate may be subject to a periodic adjustment that generally, but not always, decreases the negotiated amount of payment due to the facility for the claim. If the payment is decreased, the amount of the decrease is credited to the reserves held for this Plan. If the payment is increased, the Plan pays that cost on behalf of the enrollee.

# Definitions *continued*

## Custodial care

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

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

The Carrier, its medical staff and/or an independent medical review determines which services are custodial care.

## Durable medical equipment

Equipment and supplies that:

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

## Effective date

The date the benefits described in this brochure are effective:

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

## Enrollee

The contract holder eligible for enrollment and coverage under the Federal Employees Health Benefits Program and enrolled in the Plan.

## Experimental or investigational drug, device and medical treatment or procedure

A drug, device or medical treatment or procedure is experimental or investigational:

1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2) if reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
3) if reliable evidence shows that the consensus of opinion among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

## Definitions *continued*

**Group health coverage**

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

**Home health care**

Medical care provided to homebound patients who require continuous, active and skilled care at home.

**Home health care agency**

An organization that has a written agreement with the Local Plan to provide home health care services.

**Home hospice care program**

An integrated set of services and supplies designed to provide palliative and supportive care to terminally ill patients in their homes.

**Lifetime maximum**

The maximum amount the Plan will pay on your behalf for covered services rendered while you are enrolled in your option. Benefit amounts accrued under **High Option** and **Standard Option** are accumulated in a permanent record regardless of the number of enrollment changes.

**Local Plan**

A Blue Cross and Blue Shield Plan serving a specific geographic area.

**Medically necessary**

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

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

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

**Member rate**

See Covered charges.

**Members**

Enrollees and family members eligible for coverage under the Federal Employees Health Benefits Program and enrolled in the Plan.

**Mental conditions/ substance abuse**

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

**Non-member rate**

See Covered charges.

**Non-participating physician**

A Non-participating physician does not have an agreement with the local Blue Shield Plan. Payment can be made to the physician or to the member, at the Local Plan's option. The member is responsible for the balance, if any, between the Local Plan's payment and the physician's charge.

**Non-participating Provider Allowance (NPA)**

See Covered charges.

# Definitions *continued*

**Participating physician**

A Participating physician is one who, at the time a covered service is rendered, has a written agreement with the local Blue Shield Plan; payment is made to the Participating physician based on a negotiated allowance (PAR, see Covered charges) agreed to between the Participating physician and the Local Plan.

**Participating Provider Allowance (PAR)**

See Covered charges.

**Plan**

The Blue Cross and Blue Shield Service Benefit Plan.

**Precertification**

The requirement to contact the Local Plan serving the area where the services will be rendered before being admitted to a hospital for inpatient care, or within two business days following the admission when the hospital admission is an emergency.

**Preferred physician**

A Preferred physician is one who, at the time a covered service is rendered, has a written agreement with the local Blue Shield Plan; payment is made to the Preferred physician based on a negotiated allowance (PPA, see Covered charges) agreed to between the Preferred physician and the Local Plan.

**Preferred Provider Allowance (PPA)**

See Covered charges.

**Preferred provider organization (PPO) arrangement**

An arrangement between Local Plans and physicians, hospitals, health care institutions, or other health care professionals (or for pharmacies, PCS Health Systems, Inc.) to provide services to you at a reduced cost. The PPO (also known as the Preferred Provider Program—PPP) provides members the opportunity to reduce their out-of-pocket expenses for care by selecting facilities and providers from among a specific group of health care providers. Preferred providers are available in most locations; your use of them whenever possible helps contain health care costs and reduces your out-of-pocket costs. The selection of PPO providers is solely the Local Plan's (or for pharmacies, PCS Health Systems, Inc.) responsibility; continued participation of any specific PPO provider cannot be guaranteed.

**Preferred rate**

See Covered charges.

**Prior approval**

Written assurance that benefits will be provided from 1) the Local Plan where the services will be rendered, 2) the Retail Pharmacy Program or the Mail Service Prescription Drug Program for prescription drugs and supplies, or 3) the Carrier for the clinical trials benefit for certain organ/tissue transplant procedures. Home health care, home hospice care, certain drugs and supplies, and certain organ/tissue transplant procedures require prior approval. For further information, see page 42.

**Prosthetic appliance**

A device that is surgically inserted or physically attached to the body to restore a bodily function or replace a physical portion of the body.

**Routine services**

Services that are not related to a specific illness, injury, set of symptoms, or maternity care.

**Sound natural tooth**

A tooth that is whole or properly restored (restoration by amalgams only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth with a crown is not considered a sound natural tooth.

# Index

Do not rely on this page; it is for your convenience and is not an official statement of benefits.

# *Non-FEHB Benefits Available to Plan Members*

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

## Federal DentalBlue (Standard Option Only)

Federal DentalBlue is an optional dental product with an additional premium that complements and supplements the dental benefits included in your **Standard Option** coverage. To apply for Federal DentalBlue, you must be enrolled in **Standard Option** and reside in a Plan area listed below. To purchase this additional coverage, complete and sign the Federal DentalBlue enrollment form, which you can obtain from your Local Plan.

### Limited availability

Federal DentalBlue is available only in the following Plan areas:

- Alabama
- Colorado
- Idaho areas served by the Boise Plan
- Kentucky
- Maine
- Massachusetts
- Nebraska
- Oklahoma
- Vermont
- Virginia
- Washington areas served by the King County Medical Blue Shield Plan and Island, Klickitat, Pierce, San Juan, Skagit, Skamania, and Whatcom counties

### Plan features

- No deductible
- No claim forms with Preferred dentists
- Annual maximum of $1,000 per person

| Coverage | Payment |
|---|---|
| • Preventive and diagnostic services, such as exams, X-rays, cleanings, sealants (children only), and fluorides | In full* |
| • Basic restorative services, such as fillings and extractions | 80% MAC* |
| • Major restorative services, such as root canal therapy, crowns, bridges, dentures, and periodontal services | 50% MAC* |

*When rendered by Preferred dentists, benefits for preventive and diagnostic care are provided in full. The combined benefits of the Service Benefit Plan **Standard Option** and Federal DentalBlue will equal up to 80% of the Maximum Allowable Charge (MAC) for basic restorative services and up to 50% of the MAC for major restorative care. For covered care by Non-preferred dentists, Federal DentalBlue will provide benefits up to 80% of what would have been provided with a Preferred dentist, except where prohibited by State law.

THIS IS A PARTIAL SUMMARY OF FEDERAL DENTALBLUE. FOR MORE INFORMATION REGARDING BENEFITS, PREMIUMS, LIMITATIONS, AND EXCLUSIONS, PLEASE CONSULT THE CONTRACTUAL DESCRIPTION OF FEDERAL DENTALBLUE, WHICH CAN BE OBTAINED BY CALLING THE FEP DEPARTMENT OF YOUR LOCAL BLUE CROSS AND BLUE SHIELD PLAN.

## Vision Care Program

As a Blue Cross and Blue Shield Service Benefit Plan member, you are eligible to purchase eyewear at substantial savings. This vision program with the Eye Care Plan of America (ECPA) entitles you to savings of 20% to 60% on frames, lenses, and options such as scratch coat, UV400, tints, etc. The savings on contact lenses and other accessories is 20%. The savings on disposable contact lenses is 20% for the first 90-day supply.

Just present your Service Benefit Plan Identification Card to any of more than 6,000 participating optical providers, including retail chain store optical departments, regional optical shops, and independent optical providers. **The names, addresses, and telephone numbers of ECPA optical providers participating in this program are available by calling 1-800-551-3337. Location information is available 24 hours a day; Customer Service is available from 7:00 a.m. to 6:00 p.m., Mountain Standard Time.**

There are no enrollment fees and no additional paperwork or claim forms to be filed in this program. All charges for eyewear are handled directly between you and the ECPA provider.

## Medicare prepaid plan enrollment

Many local Blue Cross and Blue Shield Plans are offering Medicare recipients the opportunity to enroll in a Medicare prepaid plan without payment of an FEHB premium. As indicated on page 46, certain annuitants and former spouses who are covered by Medicare (Parts A or B) and FEHB may elect to drop their FEHB coverage, enroll in a Medicare prepaid plan, and later reenroll in FEHB without penalty. Those without Medicare Part A may join a Medicare prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. Contact your retirement system for information on dropping or changing your FEHB enrollment. Blue Cross and Blue Shield Plans in the following states offer Medicare prepaid plans: AZ, AR, CA, CO, DE, FL, HI, IN, MD, MA, MI, MN, MO, NJ, NY, OH, OR, PA, SC, and WA. Contact your local Blue Cross and Blue Shield Plan to find out if a Medicare prepaid plan is available in your area and the cost, if any, of that enrollment.

***Benefits on this page are not part of the FEHB contract.***

# *How the Blue Cross and Blue Shield Service Benefit Plan Changes January 1997*

Do not rely on this page; it is not an official statement of benefits.

## Benefit changes

- This Plan now offers a Point-of-Service (POS) product under Standard Option in select areas. See page 5 for additional information.
- Precertification for maternity admissions for routine deliveries is no longer required. Certification of additional days is necessary if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 72 hours after a cesarean section. Previously, all maternity admissions required precertification.
- Under **both options**, the restriction has been lifted on the provision of benefits only through clinical trials for autologous bone marrow transplants (autologous stem cell support) and autologous peripheral stem cell support for multiple myeloma. In addition, limited benefits are now available for allogeneic peripheral stem cell support for multiple myeloma through certain clinical trials (see page 19).

## Clarifications

- This Plan's type of delivery system is now identified on the brochure cover: A Managed Fee-for-Service Plan with a Preferred Provider Organization and a Point-of-Service Product.
- Procedures, services, drugs and supplies related to abortions are excluded 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.
- Surgical correction of amblyopia and strabismus is covered for all members, regardless of age.
- Reconstructive surgery to restore the mouth to a pre-cancer state is covered.
- Under Maternity Benefits, the payment levels for Preferred obstetrical care have been clarified.
- Under Maternity Benefits, the exclusion for Assisted Reproductive Technology procedures has been clarified to indicate that sperm banking is not covered.
- Under Other Medical Benefits, Outpatient facility care, outpatient hospital services in connection with dental procedures when a nondental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient are covered.
- Under Other Medical Benefits, home infusion therapy is not limited solely to intravenous therapy.
- Under Additional Benefits, benefits for the routine physical examination and the coronary artery disease screening do not apply to children eligible for Well Child Care benefits.
- Under Additional Benefits, laboratory tests as recommended by the American Academy of Pediatrics are covered under Well Child Care benefits.
- Under Prescription Drug Benefits, the Billed charge from a Non-preferred retail pharmacy must be no more than the pharmacy's normal retail charge.
- A Preferred dentist or oral surgeon who accepts the MACs as payment in full for Standard Option dental fee schedule services may not be a Preferred provider for oral surgical procedures.
- Under Liability Insurance and Third Party Actions, the Plan's subrogation and recovery rights have been clarified.
- Precertification is not required for hospital admissions in Puerto Rico.
- Under This Plan and Medicare, the precertification requirement for hospital admissions is waived for Medicare enrollees only when Medicare Part A is the primary payer.
- Under This Plan and Medicare, for Inpatient Hospital Benefits, the Plan will not waive the difference between the Average charge and the Billed charge at a Non-member hospital once Medicare benefits have been exhausted.
- The use of a Plan identification card to obtain benefits after you are no longer enrolled in the Plan is a fraudulent action subject to review by the Inspector General.
- Medical data that does not identify individual members may be disclosed as a result of bona fide medical research or education.
- **PPO arrangements** This section has been clarified to show that while PPO providers agree with the Plan to provide covered services, final decisions about health care from PPO providers are the sole responsibility of the doctor and are independent of the terms of the insurance contract. Also clarified is the fact that PPO benefits apply only when you use a PPO provider. If no PPO provider is available, or you do not use a PPO provider, the non-PPO benefits apply.

# *How the Blue Cross and Blue Shield Service Benefit Plan Changes January 1997* continued

## Clarifications

*continued*

- **General Information** When a family member is hospitalized on the effective date of an enrollment change and continues to receive benefits under the **old** plan, benefits under the **new** plan will begin for other family members on the effective date of the new enrollment.

  An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition.

  Annuitants and former spouses with FEHB coverage, and who are covered by Medicare Part B, may join a Medicare prepaid plan if they do not have Medicare Part A, but they will probably have to pay for hospital coverage. They may also remain enrolled under an FEHB plan when they enroll in a Medicare prepaid plan.

  Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

  Temporary continuation of coverage (TCC) for employees or family members who lose eligibility for FEHB coverage includes one free 31-day extension of coverage and may include a second. How these are coordinated has been clarified; notification and election requirements have also been clarified.

  "Conversion to individual coverage" does not require evidence of good health and the Plan is not permitted to impose a waiting period or limit coverage for preexisting conditions; benefits and rates under the individual contract may differ from those under the FEHB Program.

- The rules concerning whether this Plan or Medicare pays your claim first when you are entitled to benefits under both this Plan and Medicare have been clarified (see page 43):
  - This Plan is primary if you, the enrollee, are age 65 or over, have Medicare, and are employed by the Federal Government. If your covered spouse is age 65 or over, has Medicare, and is employed by the Federal Government and you, the enrollee, are not, Medicare is primary.
  - Medicare is primary if you are a former Federal employee receiving workers' compensation and the Office of Workers Compensation has determined that you are unable to return to duty.

## Other changes

- In Connecticut, when this Plan pays secondary benefits to other Blue Cross and Blue Shield coverage, Preferred physicians now can collect the difference between the Plan's payment and the physician's charge.
- The "Flexible services option" is now known as the "Flexible benefits option."
- Enrollees who change their FEHB enrollments using Employee Express may call the Employee Express HELP number to obtain a letter confirming that change if their ID cards do not arrive by the effective date of the enrollment change.
- **If you are eligible for Medicare,** the information about Medicare coverage that you must disclose to the Carrier now includes your enrollment in a Medicare prepaid plan. When you are enrolled in both this Plan and a Medicare prepaid plan, this Plan will not waive any deductibles or coinsurance.
- The fact that an enrollee does not have a vested right to receive the benefits in this brochure in 1998 or later years, nor to benefits for years prior to 1997 unless those benefits are in this brochure, is now stated under "General Limitations" as well as on page 2.
- The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation or by a similar agency under another Federal or State law. The Carrier is entitled to be reimbursed by OWCP (or the similar agency) for services it paid that were later found to be payable by OWCP (or the agency).
- **Disputed claims** If your claim for payment or services is denied by the Carrier, and you decide to ask OPM to review that denial, you must first ask the Carrier to reconsider their decision. You must now request their reconsideration within six months of the denial (previously, you had one year to do this). This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.

  Providers, legal counsel, and other interested parties may act as your representative in pursuing payment of a disputed claim **only** with your written consent. Any lawsuit to recover benefits on a claim for treatment, services, supplies, or drugs covered by this Plan must be brought against the Office of Personnel Management in Federal court and only after you have exhausted the OPM review procedure.
- Arkansas and Idaho are no longer designated as Medically Underserved Areas.

# *Summary of Benefits for the Blue Cross and Blue Shield Service Benefit Plan High Option—1997*

**Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). All items below with an asterisk (*) are subject to the $150 calendar year deductible. This Plan has two options; a summary of benefits for the **Standard Option** is located on page 58 of this brochure.

| | Benefits | High Option Pays | Page |
|---|---|---|---|
| **Inpatient care** | **Hospital** | **PPO benefit:** 100% for unlimited days with no per admission deductible<br>**Non-PPO benefit:** After $100 per admission deductible, 100% for unlimited days | 15 |
| | **Surgical** | **PPO benefit:** 95% PPA for physician services<br>**Non-PPO benefit:** For physician services, 80% Allowable charge | 18-20 |
| | **Medical** | **PPO benefit:** 95% PPA for physician medical care<br>**Non-PPO benefit:** For physician medical care, 80% Allowable charge | 16 |
| | **Maternity** | **PPO benefit:** 100% PPA for physician obstetrical care<br>**Non-PPO benefit:** Same benefits as for illness or injury | 21-22 |
| | **Mental Conditions** | Covered charges up to 120 days per calendar year; 80%* Allowable charge for inpatient physician care<br>**PPO benefit:** You pay up to $75 per day for the first 120 days; all charges thereafter<br>**Non-PPO benefit:** You pay up to $150 per day in Member hospitals and up to $300 per day in Non-member hospitals for the first 120 days per calendar year; all charges thereafter | 23 |
| | **Substance Abuse** | One treatment program (28-day maximum) per lifetime | 24 |
| **Outpatient care** | **Hospital** | **PPO benefit:** You pay up to $10 per day in connection with outpatient surgery; you pay up to $10* per day for other outpatient care not related to outpatient surgery or accidental injury care<br>**Non-PPO benefit:** You pay up to $50 per day at Member facilities, and up to $100 per day at Non-member facilities, in connection with outpatient surgery; you pay up to $50* per day at Member facilities, and up to $100* per day at Non-member facilities, for other outpatient care not related to outpatient surgery or accidental injury care | 25, 30 |
| | **Surgical** | **PPO benefit:** 95% PPA for physician services<br>**Non-PPO benefit:** For physician services, 80% Allowable charge | 18-20 |
| | **Medical** | **PPO benefit:** $10 copay per covered visit<br>**Non-PPO benefit:** For home and office visits, 80%* Allowable charge | 26 |
| | **Maternity** | **PPO benefit:** 100% PPA for physician obstetrical care<br>**Non-PPO benefit:** Same benefits as for illness or injury | 21-22 |
| | **Home Health Care** | 100% of covered home health care agency charges up to 90 days per calendar year (Also see page 27 for Home nursing care benefit.) | 30 |
| | **Mental Conditions/ Substance Abuse** | **PPO benefit:** You pay up to $10* per day at Preferred facilities for outpatient facility care<br>**Non-PPO benefit:** You pay up to $50* per day at Member facilities, and up to $100* per day at Non-member facilities, for outpatient facility care; Plan pays 70%* Allowable charge for outpatient professional care for mental conditions/substance abuse, up to 50 visits per calendar year | 24 |
| **Emergency care (Outpatient accidental injury care)** | | 100% for hospital and physician services rendered within 72 hours of injury | 30 |
| **Prescription drugs** | | **PPO benefit:** (Retail Pharmacy Program) After $50 prescription drug deductible, 85% PPA | 32 |
| | | **Non-PPO benefit:** (Retail Pharmacy Program) After $50 prescription drug deductible, 65% of Billed charge | 32 |
| | | Mail Service Prescription Drug Program: $8 per prescription copay | 33 |
| **Dental care** | | Dental services required due to accidental injury; and covered oral and maxillofacial surgery | 20, 27 |
| **Additional benefits** | | Preventive services provided by **PPO** providers, Home hospice care, Well child care, and Skilled nursing facility care | 29-31 |
| **Protection against catastrophic costs** | | 100% Covered charges when applicable coinsurance and deductibles reach $1,000 per contract in a calendar year when **PPO** providers are used and $2,700 when they are not | 40 |

# *Summary of Benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option—1997*

**Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). All items below with an asterisk (*) are subject to the $200 calendar year deductible. This Plan has two options; a summary of benefits for the **High Option** is located on page 57 of this brochure.

| | Benefits | Standard Option Pays | Page |
|---|---|---|---|
| **Inpatient care** | **Hospital** | **PPO benefit:** 100% for unlimited days with no per admission deductible<br>**Non-PPO benefit:** After $250 per admission deductible, 100% for unlimited days | 15 |
| | **Surgical** | **PPO benefit:** 95%* PPA for physician services<br>**Non-PPO benefit:** For physician services, 75%* Allowable charge | 18-20 |
| | **Medical** | **PPO benefit:** 95%* PPA for physician medical care<br>**Non-PPO benefit:** For physician medical care, 75%* Allowable charge | 16 |
| | **Maternity** | **PPO benefit:** 100% PPA for physician obstetrical care<br>**Non-PPO benefit:** Same benefits as for illness or injury | 21-22 |
| | **Mental Conditions** | Covered charges up to 100 days per calendar year; 60%* Allowable charge for inpatient physician care<br>**PPO benefit:** You pay up to $150 per day for the first 100 days; all charges thereafter<br>**Non-PPO benefit:** You pay up to $250 per day in Member hospitals and up to $400 per day in Non-member hospitals for the first 100 days per calendar year; all charges thereafter | 23 |
| | **Substance Abuse** | One treatment program (28-day maximum) per lifetime | 24 |
| **Outpatient care** | **Hospital** | **PPO benefit:** You pay up to $25 per day in connection with outpatient surgery; you pay up to $25* per day for other outpatient care not related to outpatient surgery or accidental injury care<br>**Non-PPO benefit:** You pay up to $100 per day at Member facilities, and up to $150 per day at Non-member facilities, in connection with outpatient surgery; you pay up to $100* per day at Member facilities and up to $150* per day at Non-member facilities, for other outpatient care not related to outpatient surgery or accidental injury care | 25, 30 |
| | **Surgical** | **PPO benefit:** 95%* PPA for physician services<br>**Non-PPO benefit:** For physician services, 75%* Allowable charge | 18-20 |
| | **Medical** | **PPO benefit:** $10 copay per covered visit<br>**Non-PPO benefit:** For home and office visits, 75%* Allowable charge | 26 |
| | **Maternity** | **PPO benefit:** 100% PPA for physician obstetrical care<br>**Non-PPO benefit:** Same benefits as for illness or injury | 21-22 |
| | **Home Health Care** | No current Home health care benefit (See page 27 for Home nursing care benefit.) | 27 |
| | **Mental Conditions/ Substance Abuse** | **PPO benefit:** You pay up to $25* per day at Preferred facilities for outpatient facility care<br>**Non-PPO benefit:** You pay up to $100* per day at Member facilities, and up to $150* per day at Non-member facilities, for outpatient facility care; Plan pays 60%* Allowable charge for outpatient professional care for mental conditions/substance abuse, up to 25 visits per calendar year | 24 |
| **Emergency care (Outpatient accidental injury care)** | | 100% for hospital and physician services rendered within 72 hours of injury | 30 |
| **Prescription drugs** | | **PPO benefit:** (Retail Pharmacy Program) After $50 prescription drug deductible, 80% PPA | 32 |
| | | **Non-PPO benefit:** (Retail Pharmacy Program) After $50 prescription drug deductible, 60% of Billed charge | 32 |
| | | Mail Service Prescription Drug Program: $12 per prescription copay | 33 |
| **Dental care** | | Fee schedule allowances for diagnostic and preventive services, fillings, and extractions. Higher level fee schedule allowances for children up to age 13; dental services required due to accidental injury; and covered oral and maxillofacial surgery | 20, 27, 34-35 |
| **Additional benefits** | | Preventive services provided by **PPO** providers, Home hospice care, Well child care, and Skilled nursing facility care | 29-31 |
| **Protection against catastrophic costs** | | 100% Covered charges when applicable coinsurance and deductibles reach $2,000 per contract in a calendar year when **PPO** providers are used and $3,750 when they are not | 40 |